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# Blueprint of Regional Health District Formation in the State of Connecticut.

Michael Jame Hilton

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**THE BLUEPRINT OF REGIONAL HEALTH DISTRICT  
FORMATION IN THE STATE OF CONNECTICUT**

**Michael James Hilton**

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**A Thesis**

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**Master of Public Health Thesis**

**THE BLUEPRINT OF REGIONAL HEALTH DISTRICT  
FORMATION IN THE STATE OF CONNECTICUT**

**Presented by**

**Michael James Hilton, B.S.**

**Major Advisor**

  
**Hal Mark**

**Associate Advisor**

  
**Paul Schur**

**Associate Advisor**

  
**Hal Burdo**

**University of Connecticut**

**1996**

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# INTRODUCTION

## BACKGROUND

### *Local Health Services in Connecticut*

Currently, in Connecticut, the three options for providing local public health services are: (1) a municipal health department with a part-time director of health; (2) a municipal health department with a full-time director of health; and (3) a regional health district. Each municipal health department or regional health district is required by Connecticut General Statutes to have a director of health (Section 19a-368 of the Connecticut General Statutes). Elected officials in a municipal health department and a board of directors in regional health districts appoint the director of health; all appointments are subject to approval by Connecticut's Commissioner of Health. Upon the appointment of the regional health district director of health, the terms of office of the directors of health of the municipalities forming the district shall terminate. Municipal health departments are required by the Connecticut General Statutes to have a full-time director of health if the town's population is 40,000 or more. The director of health of a municipal health department or a regional health district is required to be a licensed physician or a graduate of an accredited Master's of Public Health Program. In a municipal health department, a person with appropriate academic training and experience may also be considered for the position of director of health. The Connecticut General Statutes (whether a municipal health department or a regional health district) provide the director of health with the authority to enforce Connecticut rules and regulations in accordance to the Connecticut Public Health Code.

In addition to the director of health, the Connecticut General Statutes require that municipal health departments and regional health districts have a certified sanitarian who reports to the director of health. The director of health and the licensed sanitarian

have the authority to choose the remaining staff for their department or district (Section 19a-f-368 of the Connecticut General Statutes).

### **Municipal Health Departments**

In Connecticut, ninety-five towns are served by a municipal health department. Approximately, three quarters of these towns are served by a full-time director of health, while one quarter is served by a part-time director of health. Municipal health departments with a part-time director of health are not eligible for state funds. Their funding comes from municipal contributions. Municipal health departments with a full-time director of health are eligible for funding from the state in the amount of \$0.52 per capita (State Department of Public Health and Addiction Services, 1993).

### **Regional Health Districts**

In Connecticut, there are sixteen regional health districts serving seventy-four towns. These regional health districts contain two to thirteen individual Connecticut towns. The regional health district is a full-time public health department serving the designated participating towns. The regional health district's primary mission is the promotion of public health and disease prevention. The creation of a regional health district provides the constituent towns with a full-time health director and staff and a corresponding transfer to the district of the duties and responsibilities previously delegated to towns. State financial support is available. Additionally, the district health director presides over district-wide planning, education, and health coordination, in lieu of the present cooperative or specialized arrangements. The district is funded by contributions from the participating towns, block grants, state assistance (\$1.78 per capita for each town with a population of 5,000 or less; \$1.52 per capita for towns whose population is more than 5,000), and district revenues.

The regional health district is governed by a board of directors with representatives from the participating towns. Towns are represented in proportion to their population, based on a state formula: one representative per ten thousand people in town population base, plus one representative for each individual per town over that multiple (see Appendix D) This board of directors shall meet at least quarterly and at other times as determined by its chairperson. Its duties shall include the promulgation of rules and regulations for the general health within the district, which do not conflict with law or the Public Health Code. Its powers shall include but not be limited to the following:

1. to sue and be sued;
2. to make and execute contracts;
3. to make, amend, and repeal bylaws, rules and regulations;
4. to have whatever other powers are necessary to properly carry out its powers as an independent entity of government (Christoffel, 1982).

### **Advantages of regional health districts**

In Connecticut, the majority of the existing regional health districts formed in order to consolidate resources and services, to maintain quality, and to provide a wider array of services. The following are identified as advantages of a regional health district:

1. Services of a fully staffed health department, that is well-trained and qualified for professional positions.
2. A greater capacity to fulfill state mandates.
3. Improved availability and scope of services.
4. Back-up support. Pooling of manpower for back-up services.
5. Greater organizational capacity to assess community health status, develop policy, and manage programs and personnel.
6. Uniform enforcement of state laws, regulations, codes, and ordinances.

7. Regional approach to public health problems that cross town lines.
8. Enhanced efficiency and coordination of services.
9. Improved accountability and oversight.
10. Sharing of resources with neighboring communities that have similar needs.
11. Improved ability to manage legal risks.

### **Disadvantages of regional health districts**

The problems and pitfalls of establishing a regional health district may relate to the political structure of the individual towns. Local town politics often dictate the direction of the district formation process. The following are identified as disadvantages of a regional health district:

1. May be more costly to some towns than present part-time services.
2. Revenue from inspections and permits goes to the district.
3. Some limits to local autonomy.
4. Some limits to local control over policies.
5. Cost is assessed on a per-capita basis.

### **Public Health Program**

According to the Connecticut Public Health Code (Section 19a-76-(1) to (4)), municipal health departments and regional health districts that receive state funding must have a public health program which includes the basic eight services: (1) public health statistics; (2) health education; (3) nutritional services; (4) communicable disease control; (5) maternal and child health; (6) environmental services; (7) community nursing services; and (8) emergency medical services.

## OVERVIEW

The Healthy Connecticut Initiative states the following on local public health services:

Local governments, in cooperation with the federal and state governments, have a legal responsibility for the protection and promotion of the community's health. A governmental presence at the local level is necessary to ensure that health concerns are identified and monitored; to mobilize resources to correct problems; and to assure that the crucial services are received. It is through the local component of public health delivery system that communities and their inhabitants gain access to the benefits of public health protection. However, approximately twenty percent of Connecticut residents live in communities that still do not provide adequate public health services. This leaves these towns vulnerable to environmental health hazards and outbreaks of preventable disease (Healthy Connecticut Initiative, 1995).

Traditionally, throughout the United States, local health services have been provided by the local health departments and municipalities. Localities are responsible for: (1) the assessment, monitoring, and surveillance of local health problems and needs and of resources for dealing with them; (2) policy development and leadership that foster local needs and that advocate equitable distribution of public resources and complementary private activities commensurate with community needs; and (3) assurance that high-quality services, including personal health services, needed for the protection of public health in the community are available and accessible to all persons; that the community receives proper consideration in the allocation of federal, state, and local, resources for public health; and that the community is informed about how to obtain public health, including personal health services, and how to comply with public health requirements (Institute of Medicine, 1988).

The public health of Connecticut's citizens is protected and assured by health laws embodied in the Public Health Code of the State and by other state laws as well as local ordinances, rules and regulations. The Public Health Code covers a wide range of health protection to which every citizen is entitled. Examples of health protection

entitlements are: (1) immunizations against disease; (2) inspection of public and private water supplies; (3) control of insects and rodents; (4) consistent inspections of restaurants, food stores, factories, and schools; (5) enforcement of codes which control the disposal of wastes; (6) enforcement of health codes for private dwellings and public buildings; (7) control and reporting of communicable diseases; (8) provision of maternal and child care services; (9) enforcement of sanitary rules and regulations; and (10) maintenance of local community health clinics for the preservation of health and the prevention or control of disease (Rossetti, 1988).

In Connecticut, meeting the health protection entitlements in the face of rising costs and limited resources is a problem of growing concern. In 1991, the Commission to Study the Management of Connecticut State Government explained the importance of comprehensive local public health services to the physical and economic well-being of individuals and communities. Local public health departments are the public's first line of defense against disease and other hazards to health. However, tightening municipal budgets has made it difficult to provide needed public health services as well as fulfilling state mandates (Healthy Connecticut Initiative, 1995). For some Connecticut municipalities the challenge exists in the inability of the present system of part-time town health directors to meet the current and expected demands for service.

Recent studies (Healthy Connecticut Initiative, 1995) of Connecticut's conservative, part-time approach to local public health administration and management have consistently pointed out the need for an alternative approach. The rising requirements of public health, environmental concerns, and the demands of the local constituency make it so. More often than not the part-time director of health is a busy medical practitioner or town official who may or may not have formal training in public

health, who has little time to devote to evaluating the public needs of the community, and who is given little or no funds with which to initiate or expand needed services. The part-time health director is provided with staff assistance; however, often this is only part-time and the individual's qualifications are sometimes limited (State Department of Public Health and Addiction Services, 1993). The part-time status of all key functionaries mitigates against any continuity of programs or assessment of their effectiveness. Due to the necessarily large amount spent on priority health needs, only minimal attention can be given to such important activities as health education, the maintaining of vital statistics on the incidence of diseases, and the identification of health needs and keeping close contacts with other local or private health associations and agencies (State Department of Public Health and Addiction Services, 1993).

It is of the writer's opinion (by interviewing Connecticut regional health district directors) that the part-time health director system does work in some instances, however, it does not meet all current, let alone future, needs or demands for public health services. Therefore, the option of regional health districts should be considered. The formation of regional health districts is an effective process for consolidating resources and funds to meet Connecticut's public health needs. The evolution of state legislation concerning the health district concept dates back to 1795. Authority for voluntary participation of towns in unified health districts was included in a 1918 state statute. By the early 1940s, the State Health Department was convinced that regional organization was appropriate and necessary for improved provision of public health services. Thus, in 1947, provision was made to encourage the formation of such districts by making available state funds to establish and to operate health districts (Hanlon, 1973). Due to Connecticut's political climate, state requirements, and lack of established need to change, the first regional health district in the state was not formed



until 1966 (Weston Westport Health District Proposal, 1965). At this time, twelve out of the sixteen regional health district directors ,that the writer interviewed, agreed that escalating costs and strained municipal budgets motivated municipalities to form regional health districts in order to improve or maintain public health services and to control costs.

Over the past thirty years in Connecticut, regional health districts have continued to be formed (see Appendix A). Two of the regional health district proposals provide examples of the apparent determination to promote full-time regional health districts. The two regional health district proposals provide similarities in the district formation process while spanning over twenty-two years.

In 1973, the Intertown Health District Committee (Farmington Valley Health District) identified the inability of the present system of part-time town health officers to meet the current and expected demands for services. The committee stated:

Intensifying these already present deficiencies in the quality and quantity of services is a rapidly increasing population and other fundamental changes in the character of the Farmington Valley area. For these reasons a strong need is clearly indicated for the implementation of long-range planning, an increased capability to provide a wider array of health services to the public, and for improved coordination of the services available (Report of the Intertown Health District Committee, 1973).

In 1995, the formation of the West Hartford-Bloomfield Health District was triggered by the following advantages: (1) increased state per capita funding; (2) enhanced revenue; (3) attractive gains for Block Grant/Demonstration Project funding; and (4) program efficiency. Currently in Connecticut, over 975,000 state residents are served by one of the sixteen existing regional health districts which cover over seventy towns and four boroughs (West Hartford-Bloomfield Health District, 1995) (see Appendix A).

In collaboration with the Healthy Connecticut Initiative, the writer's opinion is that, in Connecticut, regional health districts have been formed by pioneers who basically invented their own district. Each regional health district proposal is unique, however, the lack of a structured process creates problems with consistency and quality control. In the Team Handbook--How To Use Teams and Committee's To Improve Quality, Peter Scholtes states:

A structured organized process for completing any mission is essential if success is desired. Granted, sometimes, ad hoc procedures do complete missions, however, at what risk. By maintaining and following a set of structured procedures, results can be obtained more efficiently and effectively. More growth and learning can be achieved under this format (Scholtes, 1991).

This essay will develop an explanation of the key steps of the regional health district formation process. These steps were formed from a collective effort of the State Department of Public Health and Addiction Services and the Healthy Connecticut Initiative. A number of Connecticut communities (such as Chaplin, Coventry, Mansfield, Preston, Stonington, and Windham) were interested in exploring the regional health district option for their own individual towns. However, no structured document was in existence for communities to review. Therefore, this essay will provide Connecticut communities with an option for forming a regional health district. This essay provides a structure for regional health district formation that is based on a collaboration of previous structures of existing regional health district formation processes. This essay is important in helping Connecticut's public health professionals to organize, assess, monitor, and create a system that will fulfill the public health needs of all Connecticut citizens. There are eight steps of action for planning a regional health district, and these fall under the following four district formation categories (I-IV):

## I. PRESENT LOCAL PUBLIC HEALTH SYSTEM IS ASSESSED

Prior to the actual district formation planning process, it is necessary to conduct an assessment of local needs. Each town is unique in social structure, political climate, and historical background, all of which must be considered in determining community requirements. The assessment should provide information about the type of public health services available in a particular region or town system; budgetary issues/costs of existing services; health concerns and status of the community; compliance with current state regulations; and limitations of the local health department (see Appendix B).

STEP ONE: Form a guidance team.

STEP TWO: Conduct local needs assessment.

## II. MULTI-TOWN STEERING COMMITTEE DETERMINES FEASIBILITY

STEP THREE: Form a multi-town steering committee.

STEP FOUR: Review local assessments.  
Look for common goals and needs.

STEP FIVE: Review responsibilities and functions of health districts.

STEP SIX: Determine district programs and services.  
Address staffing and operational issues.

## III. DISTRICT PROPOSAL IS DEVELOPED

First, subcommittees for proposal-writing and budget must be formed.

Then the Steering Committee's findings must be reviewed.

STEP SEVEN: Develop a budget for the new district.

STEP EIGHT: Draft a district proposal.

## IV. NEW DISTRICT IS APPROVED BY EACH TOWN

Organizational, leadership, and policy development take place and the district becomes operational.

## **STEPS FOR PLANNING A REGIONAL PUBLIC HEALTH DISTRICT**

### **STEP ONE:**

#### **FORM A GUIDANCE TEAM**

The guidance team is the group of health professionals and other key leaders in the local participating towns who oversee and support the activities of the steering committee. Often these are the same individuals who chose to form the district and appointed the steering committee members in the first place, but other people may be involved. For example, politicians play key roles in the decision making process. The political structure of individual towns can drive the district to success or failure. The political agenda and reality of local town government is powerful and overwhelming (Studnicki and Steverson, 1994).

**The guidance team should have three to six members (so that the team can be manageable, focused, and timely), with the following qualifications:**

- diverse skills and resources
- a stake in the chosen process
- authority to make changes in the process under study
- clout and courage (Scholtes, 1991)

One or two members of the guidance team will likely be professionals or town officials who have established authority and responsibility regarding the process they want studied. A common problem in conventional organizations is that decisions are often made by the wrong people, meaning people without the facts or the authority to make such decisions (Senge, 1990).

Guidance team members do not conduct the actual project; rather, they guide the efforts of the steering committee. They appoint the steering committee chairperson and, together with that leader determine the project's goals and select the other committee members. They make certain the steering committee chairperson has whatever resources that are needed to be successful (Cleveland, 1992).

**The duties of the guidance team occur in two phases:**

1. Before the steering committee begins operations, the guidance team should:

- identify the steering committees goals
- prepare a mission statement
- determine needed resources
- select the steering committee chairperson
- appoint the quality advisor
- select the steering committee members

2. During the operation of the steering committee, the guidance team will:

- meet regularly with the steering committee
- develop and improve systems that allow committee members to bring about change. This includes opening communication lines between the committee, townspeople, and local health department members.
- when necessary, "run interference" for the steering committee, representing its interests to the public sector.
- insure that decisions made by the team committee are implemented.

**Laying the groundwork**

The officials who select the project of regional health district formation, or the guidance team, have important issues to consider before a steering committee begins operations (Reeves, 1989).

**They must:**

- identify the goals
- prepare a mission statement
- determine the resources
- select a steering committee chairperson
- assign the quality advisor
- select the steering committee members

## **STEP TWO:**

### **CONDUCT LOCAL NEEDS ASSESSMENT**

The second Step in the formation of a regional health district is conducting a local public health needs assessment study. Towns should be aware of their present public health needs before making any decision to join a regional health district. Each town has a unique structure, therefore, a town must consider its political components, history, values, and business development. According to the Healthy Connecticut

Initiative:

A needs assessment is a study that analyzes existing resources, identifies needs and assists in setting priorities. A needs assessment is a tool to aid a town in making informed decisions about municipal spending on public health and the need for services when a town becomes a member of a health district (Healthy Connecticut Initiative, 1995).

The public health needs assessment provides towns with the answers to the following statements:

- The current costs of providing public health services within the town.
- What public health services are being provided by the town.  
What public health services are not being provided by the town.
- Is the present system meeting state requirements.
- Is the towns population healthy.
- What is the municipal health departments organizational capacity.

It is the writer's opinion that dedication is the key to conducting a public health needs assessment. Furthermore, leadership is a necessity for the public health needs assessment study. A leader must guide the process in order to gather important

information and to be able to use that information productively (Senge, 1990).

The Healthy Connecticut Initiative suggests six steps to conduct a public health needs assessment. These six steps have been proven successful by the Healthy Connecticut Initiative's regional public health needs assessment for nine eastern Connecticut towns (Spargo and Traugh, 1995). The six steps are:

1. form a local study committee
2. collect health data
3. inventory public health service providers
4. survey public health service providers
5. conduct municipal capacity survey
6. recommend public health goals



### **STEP THREE:**

#### **FORM A MULTI-TOWN STEERING COMMITTEE**

The third Step in the formation of a regional health district is to form a multi-town steering committee. The function of a multi-town steering committee is to determine which towns are interested in exploring the formation of a new regional health district. A multi-town steering committee should contain members from a variety of disciplines: activity groups, non-profit/for-profit establishments, local existing health services personnel, town officials, politicians, public health professionals, and local town citizens. The success of a new regional health district depends upon the action taken by the steering committee during the formation process. (Each of the sixteen existing regional health districts utilized some sort of committee during the beginning stages of district formation, however, they did not use this exact model.) The steering committee must be competent and not too large. If the steering committee contains too many members, then effective, timely, and workable decision-making processes become difficult and unobtainable (Scholtes, 1991). The steering committee must therefore maintain a workable size as well as a well-balanced membership. Generally, when the steering committee is formed participants are stimulated to form a regional health district when personal and political agendas are met. The intentions of steering committee members can greatly affect the outcome of the steering committee.

#### **Steering committee members:**

- should consider their participation in the steering committee as a priority responsibility
- should be responsible for contributing to the regional district

formation project as fully as possible

- should carry out the following assignments or tasks between meetings: observing processes, gathering data, writing reports, and reporting back to other town officials (Spargo and Traugh, 1995).

Since a new regional health district will touch the lives of many people in the participating towns, it is most important to clearly define the roles of the active participants in the steering committee. These include the following:

- **Steering Committee Chairperson**, who runs the team, arranges logistical details, facilitating meetings, and so forth.
- **Steering Committee Members**, who form the bulk of the team, carry out assignments and make improvements. Enthusiastic, hard-working steering committee team members contribute most to the success of a project such as district formation, but they must be given an effective team system within which to work. This depends on the guidance team, steering committee chairperson, and quality advisor. A successful district requires careful selection of people to fill these roles and orchestration of their activities. The following guidelines, containing detailed descriptions of the positions and duties mentioned above, will help a district make these choices (Scholtes, 1991).

#### *STEERING COMMITTEE CHAIRPERSON*

The steering committee chairperson (selected by the guidance team) is the person who manages the steering committee: calling and facilitating meetings, handling or assigning administrative details, orchestrating all team activities, and overseeing preparations for reports and presentations. The chairperson should be interested in solving the problems that face this steering committee and be reasonably

good at working with individuals and groups. Ultimately, it is the chairperson's responsibility to create and maintain channels that enable committee members to do their work.

Ordinarily, the steering committee chairperson is a respected health professional in the local area who believes in the betterment of community health. Closeness to the process means better ability to guide committee members. Consequently, the chairperson must take extra precautions to avoid dominating the committee during meetings. The chairperson leaves rank outside the meeting room, facilitating discussions and only occasionally participating actively. Effective chairpersons share their responsibilities with other committee members, and trust their groups to arrive at decisions together. It is crucial that committee members be given autonomy and the ability to learn from their mistakes.

#### THE NEED OF A QUALITY ADVISOR

The guidance team and the steering committee chairperson will find that the steering committee functions more effectively when assisted by people with special training in the operations and development of regional health districts, statistics, and scientific tools. These committee consultants are called "quality advisors."

Though quality advisors attend committee meetings, they are neither leaders nor committee members. As outside observers, they can maintain a certain level of objectivity. This puts them in a better position to observe the committee's progress, evaluate team processes, and make suggestions for improving them. A quality advisor's major role is instructing committee members relative to useful scientific tools and helping to guide the committee's efforts when expertise is needed. Aside from the functions of explaining scientific tools and trouble shooting at meetings, the quality advisor works before and after the steering committee meetings,

in conference with the chairperson and the guidance team. At that time, they discuss the committee's progress and explore methods for facilitating committee operations (Senge, 1990).

### GOALS OF THE FIRST MEETINGS

The goals of a steering committee's first meetings are built around three themes: (1) building relationships between committee members; (2) learning about the regional health district formation process; and (3) starting to work towards the desired outcome (Drucker, 1988). Though the temptation is great to plunge right in to the project, it is important that the committee, in the early stages, devote equal time to all three aspects.

#### ***Team-Building Goals for the First Meetings***

- Get to know each other.
- Learn to work as a team.
- Work out decision-making issues.
- Determine support services.
- Set meeting "ground rules."

#### ***Educational Goals for the First Meetings***

- Explore quality issues.
- Learn the scientific approach.

#### ***Project Goals for the First Meetings***

- Understand your assignment.
- Understand the process.
- Identify resources.
- Develop an improvement plan (Timmreck, 1995).

## PREPARING FOR THE FIRST MEETING

The steering committee chairperson and the quality advisor are the driving forces behind the first committee team meetings. They must draft the preliminary formation plan as well as a timeline for the committee's activities. (The timeline should revolve around the municipal fiscal year.) They must also handle all the logistical details and develop an agenda that blends the three themes discussed above.

**More specifically, the quality advisor and steering committee chairperson must:**

- review the written mission statement and discuss the project in general
- clarify roles
- draft a plan of action for the regional district formation process
- identify pertinent existing data
- set the meeting logistics
- set an agenda
- plan for improving meetings (Scholtes, 1991)

## GETTING UNDERWAY

It is the writer's opinion (through literature review and research) that during the steering committee's first few meetings, it is not at all unusual for participants to feel as though they have been transported to the Land of Oz—a place completely different from what they are used to. The initial committee meetings are critical for setting a proper tone; there is serious work at hand, but everyone can have an enjoyable experience and contribute to the mission by working together. This requires members to familiarize themselves with both the process and their fellow participants. The following guidelines will help them to develop productive meeting skills and lead them through the first few meetings.

## GUIDELINES FOR PRODUCTIVE STEERING COMMITTEE MEETINGS

Though individual committee members carry out assignments between committee meetings, much of the team's work gets done when all team members are together (during meetings). Productive meetings can lead to a successful project.

### *General Meeting Rules*

- Use agenda.

Each meeting must have an agenda, preferably one drafted at the previous meeting and developed in detail by one or two members prior to the actual meeting. It should be sent to participants in advance, if possible.

- Have a facilitator.

Each meeting should have a facilitator who is responsible for keeping the meeting focused and moving. Ordinarily, this role is appropriate for the steering committee chairperson, but some teams prefer to rotate this responsibility among the members.

- Take minutes.

Each meeting should have a scribe who records key subjects and major points raised, decisions made, and items that the committee has agreed to return to at a later time. Committee members can refer to the minutes to review discussions, decisions, or plans made, or to see what happened at a meeting they missed.

- Draft next agenda.

At the end of the meeting, the committee must draft an agenda for the next meeting.

- Evaluate the meeting.

It is important to review and evaluate each meeting, even if other agenda items go overtime. The evaluation should include suggestions for improving future meetings and helpful feedback to the facilitator.

- Adhere to the "100 mile rule."

Once a meeting begins, everyone is expected to give his or her full attention. No one should be called from the meeting unless it is so important that the disruption would occur even if the meeting was a hundred miles away from the workplace. The "100 mile rule" may need to be communicated--perhaps repeatedly--to those who would keep taking phone messages or interrupt the committee's work for other reasons (Scholtes, 1991).

### ***Effective Discussion Skills***

Effective discussions are necessary for effective meetings, which in turn are necessary for effective steering committees. Every committee meeting should include actions that facilitate the process of discussion. While ensuring productive discussion is a primary responsibility of the chairperson, every committee member should develop and practice the relevant skills. The following techniques are presented in the framework of team meetings, but they are useful whenever an effective discussion is important.

#### **At appropriate times during a meeting, team members should:**

- *Ask for clarification.*

If a committee member is unclear about the topic being discussed or the logic in another person's arguments, ask someone to define the purpose, focus, or limits of the discussion.

- *Act as gatekeepers.*

Encourage more or less equal participation among committee members by "throttling" dominators.

- *Listen.*  
Actively explore one another's ideas rather than debating or defending each idea that comes up.
- *Summarize.*  
Occasionally compile what has been said and restate it to the group in summary form. Follow a summary with a question to check for agreement.
- *Contain digression.*  
Do not permit overly long examples or irrelevant discussion.
- *Manage time.*  
If portions of the agenda take longer than expected, remind the committee of deadlines and time allotments so work can be either accelerated or postponed, or time re-budgeted appropriately.
- *End the discussion.*  
Learn to determine when there is nothing to be gained from further discussion. Help the committee close a discussion and decide the issue.
- *Test for consensus.*  
Summarize the committee's position on an issue, state the apparent decision, and check whether the team agrees with the summary.
- *Constantly evaluate the meeting process.*  
Throughout the meeting, assess the quality of the discussion. Ask: Are we accomplishing what we want from this discussion? If not, what can we do differently in the remaining time (Scholtes, 1991)?

## CONDUCTING THE FIRST MEETING

The following sequence of activities has been found to be very useful for the first meeting. It incorporates elements seen in later meetings, but is arranged to introduce members to various aspects of the project. These instructions will guide a steering committee chairperson or other facilitator through the first meeting.



1. ***Before members arrive***

Arrive early. Write the meeting agenda on a flipchart page and make it visible to all; type it up and distribute copies to members as they arrive. On another flipchart page, write the goals for the steering committee, which are: (1) to determine district programs and services; (2) to assess common public health needs and goals; (3) to develop a two-year district budget; (4) to draft a district proposal; and (5) to present the district proposal to participating towns. Write down the mission statement on a third flipchart page.

2. ***Greet arrivals***

The chairperson should greet members by name and introduce himself or herself as steering committee members enter the room. Welcome each one personally.

3. ***Get started***

Establish a precedent by starting promptly. Begin the meeting at the announced starting time, even if some members have not yet arrived. Knowing that meetings will not wait for latecomers will serve as an incentive to show up on time. The chairperson should start the meeting simply by introducing himself or herself again and by explaining his or her roles: to facilitate the meetings, plan meetings and other committee activities, and serve as a contact person. Review the agenda to orient the team to this meeting.

4. ***Warm-up***

At the first meeting it works well to incorporate a five-to-ten minute get-acquainted activity while stragglers arrive.

5. ***Have members introduce themselves***

Simply go around the table and have members introduce themselves and perhaps say a few words about what they do.

6. ***Review the team's purpose***

State the mission of the steering committee. Give committee members a summary of the town needs assessment reports; a timeline for committee activities; and a copy of the district formation guidebook.

7. ***Explain the meeting goals***

Briefly outline the plan for the first few meetings: to build the team, explore quality issues, clarify the task, and further develop the regional health district concept.

8. ***Get acquainted with each other***

In the first hour of a committee's life, it is important for members to begin learning about the task and about each other. People are embarking on a new experience-stretching old patterns of work and long-standing assumptions that things will never change. That is why it is critical to emphasize from the start the importance of working together as a team.

9. ***Define roles***

After team members have described their individual jobs and roles on the committee, discuss the team's operation. Describe your role as steering committee chairperson in more depth. Explain the roles of other members.

10. ***Set ground rules***

Explain the committee's ground rules in terms of general courtesy and responsible behavior.

11. ***Complete the agenda***

**EVALUATIONS**

In many respects, evaluation is the most important and difficult activity committees will undertake. Self-critique is a committee's main source of feedback, as it is the only way to avoid letting problems go unnoticed for too long. Because the committee's work is performed or presented at meetings, one logical way to evaluate the project is to evaluate the meetings. The most natural time for evaluation is at the end of meetings, but that is sometimes difficult because people are often tired and not in the mood to challenge themselves. One way around this is to evaluate the meeting at the mid-point rather than the end.

**Structure any evaluation around two points:**

- Effectiveness: Is the committee focusing on the right targets? Asking the right questions? Tackling the right problems? Working on issues related to the project?
- Efficiency: Is the committee taking the best approach? Is the committee avoiding unnecessary steps (Turnock, 1994)?

At each meeting, a team should do both a general evaluation and a focused evaluation on how well the committee discussed specific topics. At evaluation time, each member would rate the committee on the particular items the committee has chosen. Then the committee would compare answers and discuss differences in ratings. The numbers themselves are not important; the discussion they provoke is important (Turnock, 1994).

### SETTING UP RECORD-KEEPING SYSTEMS

The final crucial element in having productive meetings and a successful steering committee is to maintain up-to-date files. Good committee records are helpful for several compelling reasons:

- Clear, illustrated records help educate and win the support of people in the town localities who may not have time to read or listen to lengthy reports.
- Good records help new members catch up and keep old members informed of developments.
- As the committee progresses, it may have to retrace its steps to track down problems or errors. Good records make this easier.
- Having up-to-date records facilitates the preparation of presentations to towns or public sources outside the committee (Turnock, 1994).

For these reasons, it is important to document the committee's work from the earliest stages. Members should discuss the kinds of records that the committee is likely to need further down the road, and plan how to maintain these records.

## **STEP FOUR:**

### **REVIEW LOCAL PUBLIC HEALTH NEEDS ASSESSMENTS**

### **LOOK FOR COMMON NEEDS AND GOALS**

During Step Two, a regional public health needs assessment has to be completed for all participating towns and communities. Step Four involves the examination of each town's public health needs. The regional public health needs assessment includes (Spargo and Traugh, 1995):

- Sociodemographic data:

- demographics

- family income

- Health status data:

- leading causes of death

- maternal and child health

- other health indicators

- health practices in the region

- The present public health system:

- local public health services and providers

- regional public health needs as identified by community

- agencies

- environmental health services

- present local health department structure

- local health department capacity assessment

- Options for providing local public health services

In this Step the question to answer is: What mix of services should be provided? Therefore, each community will seek common ground with other participating communities. This "common ground" may include several areas, such as demographics and health problems. For the overall district formation, this process of identifying common needs is essential prior to beginning the design phase of a solid regional health district. Towns will also begin to realize that some of their public health systems can complement each other. Suggested areas for comparisons of each town's needs assessment include the following:

- health department budgets
- other municipal public health services
- maternal and child health services
- demographics
- public health service providers
- epidemiological information
- health status/perceived health problems
- organizational chart for each municipal health department
- environmental health services

Analysis of the gathered information and comparisons must address several different factors which are of the utmost importance to a regional health district. A key factor to the success of such a district is the consolidation of services. Therefore, the towns must decide in which areas each community's public health systems are similar and determine whether any of the participating towns currently share resources or health department staff. Local public health revenues, fees charged, and fines accumulated must be compared. The present demand for public health services within each town must be considered. The populations of the towns need to be examined in

order to determine who is to be served by the regional health district. The total population serves as a basis for determining the demand for health services in the region. Also, a district would look at the gathered information to determine which towns presently share health programs or health care providers. This process allows a regional health district to operate more efficiently and effectively. It is also necessary, to recognize how each towns' public health service systems differs from one another. Differences need to be accounted for.

Furthermore, the other purpose discussed in this Step is to look at the overall regional picture to project the demand for services. "Each town's present system can be overlaid and service demand added up so that the level and scope of services that the district needs to provide can be estimated" (Spargo and Traugh, 1995). Towns offer a variety of health services depending upon their health needs, political policies, and established resources. Certain towns may offer particular services that other towns do not (or perhaps do not want). Therefore, many health districts have adapted to the unique service requirements of communities by using the "menu" approach.

### ***The Menu Approach***

The Menu Approach applies to the situation where one town would like to purchase additional health services, when the other participating towns do not wish to do so. This situation often arises among towns trying to form a regional health district. The Menu Approach allows a town to have a separate contract with the district and to pay a separate fee to the district for this service.

## **STEP FIVE:**

### **REVIEW THE RESPONSIBILITIES AND FUNCTIONS OF HEALTH DISTRICTS**

The completion of a public health needs assessment of the participating towns is essential to Step Five, which reviews the public health statutes, state grant-in-aid criteria, and core functions of public health. The new regional health district will use this information to set goals. These goals are important at all levels of public health service because: (1) they provide the regional health district with direction; (2) they help identify objectives; and (3) they define the district's role in the community, and they provide a basis for judging the effectiveness of the district's activities.

Step Five tries to answer the question: What governmental duties does the district have? A regional health district is a governmental entity. A regional health district has obligations to: (1) provide the "core functions" of public health to the population represented by a district; (2) meet the eligibility requirements for receiving state grants-in aid, better known as providing a "Basic Local Health Program;" and (3) fulfill specific statutory responsibilities (Spargo and Traugh, 1996).

Within a regional health district several processes must function at the same time in order to successfully run the health district as a whole. In the development of the West Hartford-Bloomfield regional health district, the twelve core functions of public health were identified as:

1. to prevent epidemics
2. to protect the environment, workplaces, housing, food and water
3. to promote healthy behaviors
4. to monitor the health status of the population

5. to mobilize community action for health
6. to respond to disasters
7. to assure the quality, accessibility, and accountability of medical care
8. to reach out to link high risk, disadvantaged individuals to needed services
9. to provide medical care when need
10. to secure a skilled public health workforce
11. to research for new insights and innovative solutions
12. to lead the development of sound health policy and planning (West Hartford-Bloomfield District, 1995).

A few of these core functions cannot be measured or completed on a timeline schedule since some are abstract in nature. However, the health district also has concrete goals. These goals involve statutory responsibilities. They can be measured and do have time criteria for completion. Chapter 368f of the Connecticut General Statutes establishes the parameters for district departments of health in Sections 19a-240 through 19a-246 (see Appendix D).

#### BASIC LOCAL HEALTH PROGRAM (see listing on page ten)

The eight point basic local health program contains requirements which a regional public health district must provide and maintain in order for the district to be eligible for state grants-in-aid. The health district must take direct responsibility for the delivery of these services to the district constituents or to ensure that these services are available from outside agencies. The State requires regional health districts to have documented service plans to prove that these services are available to member communities as a prerequisite for state grant funding (Healthy Connecticut Initiative, 1995).



## STATUTORY REQUIREMENTS

In Connecticut, statutory requirements exist for all municipal and district health departments. These requirements establish measurable and concrete goals to meet the duties and obligations of a health district or municipality. They contain built-in standards of behavior, performance criteria, and completion time. The district department's specific responsibilities (public health statutes) can be viewed in the Connecticut General Statutes (see Appendix D).

## **STEP SIX:**

### **DETERMINE DISTRICT PROGRAMS, SERVICES, AND STAFFING**

An early treatise on the law of public health and safety in the United States spelled out the government's responsibility in this regard as follows:

One of the legitimate and most important functions of civil government is acknowledged to be that of providing for the general welfare of the people by making and enforcing laws to preserve and promote the public health and the public safety. Civil society can not exist without such laws; they are, therefore, justified by necessity and sanctioned by the right of self preservation. The power to enact conditions as to the manner of its exercise as are necessary to secure the individual citizen from unjust and arbitrary interference. But even under these restrictions, the power exists in ample measure to enable government to make all needful regulations touching the well-being of society (Parker and Worthington, 1892).

The federal government plays such a dominant role in financing and regulating health care delivery and health-related research in this country that the role of the state governments in this area is easily overlooked (McKnight, 1978). In Connecticut, state statutes help define how to determine a regional health district's programs, services, and staffing.

The steering committee must focus on the requirements necessary for the functioning of an efficient and effective district by determining the appropriate mix of staffing, programs, and services. Planning is the most fundamental and most important administrative activity organizations can conduct. Formal research studies as well as informal observations show that those who plan and use basic planning methods are much more successful than those who do not (Scholtes, 1991). Effective and successful development of any health district relies on planning. One of the most challenging aspects of planning and implementing a new regional health district is to work out all of the details of each activity. The objective here is to design and develop

a health district that can provide the public health services that the member towns require. The definition of how to determine programs and services is not etched in stone. Nonetheless, the Connecticut General Statutes and the Connecticut Public Health Code must be used as a guide to determine programs and services; the towns needs assessments give details on what services are being provided and what services are not being provided.

The steering committee must take into consideration the state law that regulates the formation of health districts at this point in the planning process. Connecticut state law requires a health district to employ a full-time staff, giving priority to those already employed in each of the participating town's local health departments. The individuals may continue to be employed and take part in the new district staffing while retaining their existing rights and benefits without any penalty or interruption of their retirement pension packages. Part-time employees are not protected under the statutes; therefore, they are not entitled to the parallel benefits from the local health department to the district health department. The steering committee reviews each participating town's present health department personnel to determine the number of full-time employees that must be offered positions in the new district. The steering committee needs to examine the current status of member towns' staffing and resolve any confusion or employment questions that arise (particularly issues concerning unions).

The steering committee should utilize the worksheets entitled *Planning Health District Services*; these worksheets provide a planning framework (see Appendix E).

The steering committee must consider the following questions:

1. Are regionally identified health problems addressed in program areas?
2. Have programs in member towns, been incorporated into the district functions or have they ceased?

3. Can you explain how the new district will provide direct services in the eight basic areas or will ensure that agencies outside the district's control provide these services.
4. Is there enough information to develop a realistic, working organizational flowchart for the new regional health district?
5. What personnel options are available, i.e., benefit packages, pension plans, and insurance policies? What other areas need to be considered? What will district policy include?
6. Are any or all town health department employees transferring to the new health district?
7. If there are health service areas where availability/access is inadequate, is it clear that the new district will prioritize, develop, and implement plans to assure services to residents in these areas (Healthy Connecticut Initiative, 1995)?

## **STEP SEVEN:**

### **DEVELOP A BUDGET**

The budget is crucial in the formation of a regional health district. The projection of revenues and expenses contained in the budget proposal will be used to estimate what it will cost to operate the health district and how much member towns need to contribute. The budget provides valuable information for the successful delivery of public health services and measures (see Appendix F). The financial ramifications of any project are a major determinant in the success of that endeavor. Funding levels must be adequate to support the district's activities and sustain its financial health. If funding is insufficient, staff may have to cut back on programs and services and, in the process, jeopardize the successful accomplishment of the district's mission. The district might find itself in financial trouble if, like many new organizations, it is confronted with unanticipated expenditures. An overly generous budget, on the other hand, will be difficult to justify to cost-conscious taxpayers and town leaders. In Connecticut, the West Hartford-Bloomfield Health District considered the following important items when forming a regional health district: (1) that the district be less costly than the services currently available; (2) that the per capita rate provide additional, essential services; and (3) the actual per capita costs (West Hartford-Bloomfield Health District, 1995).

As a beginning step, the steering committee must decide on a budget proposal process which is based on true figures and realistic expectations (see Appendix G). For most existing regional health districts, the original proposed budget states the highest expenditures (Collection of District Budget Proposals, 1995-1996). This is called a Pessimistic Budget Process. It prepares the district for unexpected expenditures. It is highly recommended for regional health districts where costs can

accumulate unexpectedly. This budget includes true costs for functioning with a security blanket for unanticipated costs. Determining what it will cost to run the district requires a thorough and realistic projection of expenses, revenues, and reserve funds. These estimates should be based on figures from existing health districts similar in size and/or program to the new district. For the following considerations, the writer has chosen to categorize Connecticut regional health districts by population size (see Appendix G). The regional health districts in Connecticut can be grouped into small, medium, and large categories based on population figures. Small regional health districts in Connecticut have a population under 40,000. Medium sized districts in Connecticut have a population between and inclusive of 40,000 and 80,000. Large health districts have populations over 80,000 (see Appendix A).

**In this Step estimates for the following will need to be determined:**

- District operating expenses.
- State Preventive Block-Grant Funds.
- State grant-in-aid revenues.
- Revenues from fees, licenses, inspections, and permits.
- Municipal per capita contributions.

The following is a model of a sample budget format for a regional health district with a population of approximately 70,000 persons; a medium sized district. After the sample budget a brief description of the items in the budget will be discussed. This model utilizes the information from several regional health districts, however, it is heavily weighted on the environmental side of public health. Specific line items for other pressing health concerns (such as maternal child health and epidemiology) are not listed under personnel, however, they are represented under consultant fees expense. (Collection of District Budget Proposals, 1995-1996).

### **SAMPLE BUDGET**

#### **PERSONNEL**

1 DIRECTOR OF HEALTH	\$ _____
1 CHIEF SANITARIAN	_____
2 SANITARIAN	_____
1 INSPECTOR	_____
1 HEALTH EDUCATOR/NURSE	_____
1 MEDICAL DIRECTOR	_____
1 SECRETARY	_____
1 CLERK	_____
1 BOOKKEEPER/CLERK	_____
<b>PERSONNEL TOTAL</b>	<b>\$ _____</b>

#### **BENEFITS**

HEALTH PLAN COVERAGE	\$ _____
DENTAL PLAN COVERAGE	_____
LONG TERM DISABILITY INSURANCE	_____
LIFE INSURANCE	_____

PENSION	_____
UNEMPLOYMENT COMPENSATION	_____
WORKER'S COMPENSATION INSURANCE	_____
SOCIAL SECURITY	_____
PROFESSIONAL LICENSES	_____
TUITION REIMBURSEMENT	_____
AUTO INSURANCE.	_____
EMPLOYEE BENEFIT LIABILITY	_____
PUBLIC OFFICIALS LIABILITY	_____
TREASURER'S BOND	_____
CONNECTICUT WITHHOLDING TAX	_____
FEDERAL WITHHOLDING TAX	_____
<b>TOTAL BENEFITS</b>	<b>\$_____</b>

**OPERATING EXPENSES**

ADVERTISING	<b>\$_____</b>
AUDIT/ACCOUNTING	_____
BOARD/MEETING EXPENSES	_____
CLINICAL AND MEDICAL SUPPLIES	_____
TRAINING/CONTINUING EDUCATION	_____
CONSULTANT FEES EXPENSE	_____
CONTRACT SERVICES	_____
MEMBERSHIPS AND PUBLICATIONS	_____
FIELD SUPPLIES	_____



INSURANCE EXPENSES	_____
MILEAGE/AUTO EXPENSES	_____
OFFICE EQUIPMENT/MAINTENANCE	_____
OFFICE LOCATION EXPENSE	_____
OFFICE SUPPLIES AND EXPENSES	_____
TELEPHONE	_____
UTILITIES	_____
<b>TOTAL OPERATING EXPENSES</b>	<b>\$ _____</b>

**CAPITAL EXPENDITURES**

CONTINGENCY	\$ _____
<b>TOTAL CAPITAL EXPENDITURES</b>	<b>\$ _____</b>

<b><u>TOTAL BUDGET</u></b>	<b>\$ _____</b>
----------------------------	-----------------

MINUS	-
-------	---

<b><u>REVENUES</u></b>	<b>\$ _____</b>
------------------------	-----------------

EQUAL	=
-------	---

**TOTAL AMOUNT IN BUDGET**  
**PER MEMBER TOWN COST**

\$ _____
----------

DIVIDE	/
--------	---

**POPULATION OF REGIONAL**  
**HEALTH DISTRICT**

_____
-------

EQUAL	=
-------	---

**PER CAPITA RATE**

\$ _____
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## **A REGIONAL HEALTH DISTRICT BUDGET**

### **PERSONNEL**

In a regional health district the number of personnel depends on the amount of activities and the population size of the created regional health district. Qualifications (pre-determined in job descriptions and education/employment experiences) must be met by all professionals employed by a regional health district in order for the health district to operate efficiently. Salaries can and do vary according to district funding, levels of employee experience, the amount of responsibility allocated, and by the type of employment agreed upon. A health district has the option of offering full-time employment to all employees of the health district or full-time employment to the health director and chief sanitarian and contracts for all other employees. A contract for an employee usually requires a higher salary, but benefits are not included in the position. Full-time employees are entitled to a benefit package including a range of services, such as medical insurance and pension plans. In addition, a health district can employ personnel on a part-time basis. A health district has to look into these options in order to find the ones that best meets the district's needs financially and professionally (see Appendix H).

An example of a regional health district's personnel and salary levels, based on a district with a population of approximately 70,000 persons, and excluding overtime is as follows:

1 Director of Health	\$ 53,000
1 Chief Sanitarian	49,000
2 Sanitarians	75,000
1 Part-time Health Inspector	15,000
1 Part-time Medical Director	12,000
1 Health Educator/Nurse	33,000
1 Secretary	25,000
1 Part-time Clerk	10,000
1 Part-time Bookkeeper/Clerk	10,000
<b>Personnel Subtotal</b>	<b>\$282,000</b>

According to state law, full-time personnel from member town's local health departments have first priority for positions in the new regional health district departments. Therefore, a regional health district has to investigate and to take into consideration current salaries and benefit packages of existing employees. These employees are entitled to receive and maintain their current salary and benefit packages

The issue of overtime has to be addressed. Unexpected events happen and require additional services. A regional health district must provide these services and must make funds available for its staff in overtime situations.

Furthermore, a regional health district has to estimate the amount for fringe benefits for all employees of the district. The current estimation for budget purposes is a fringe at thirty percent of the annual salary for each full-time employee and a fringe at fifteen percent of the annual salary for each part-time employee.

For example, from the salaries above:

1 Director of Health	\$ 53,000 * 30% =	\$15,900
1 Chief Sanitarian	49,000 * 30% =	14,700
2 Sanitarians	75,000 * 30% =	22,500
1 Health Inspector (P/T)	15,000 * 15% =	2,250
1 Health Educator/Nurse	33,000 * 30% =	9,900
1 Medical Director (P/T)	12,000 * 15% =	1,800
1 Secretary	25,000 * 30% =	7,500
1 Clerk (P/T)	10,000 * 15% =	1,500
1 Bookkeeper/Clerk (P/T)	10,000 * 15% =	1,500

<b>FRINGE SUBTOTAL</b>	<b>\$77,550</b>
------------------------	-----------------

## **BENEFITS**

### **•MEDICAL BENEFITS:**

For full-time employees, a regional health district must examine the issues of medical health benefits. The majority of Connecticut health districts are enrolled in Blue Cross/Blue Shield for base coverage and major medical insurance with a deductible. In addition, several regional health districts are offering HMO options to their employees, and some regional health districts are switching completely to HMO plans due to the cost reductions and the maintenance of quality service. Currently, in the majority of existing regional health districts, employees do not pay a portion of the premium for medical insurance. Co-pays for prescriptions range from as little as seventy-five cents to five dollars or twenty percent of prescription costs.

The following provides estimates on average costs for medical plans in Connecticut regional health districts.

***Medical Plans***

Average cost for individual (HMO)	\$2,822	\$235/mo.
Average cost for individual (non-HMO)	\$5,853	\$488/mo.
Average cost for family (non-HMO)	\$7,872	\$656/mo.

**•DENTAL BENEFITS:**

Eighty-six percent of Connecticut's health districts provide dental plan coverage. Plans vary considerably by options, payment schedules, costs, and the right of dentist choice. Cost determination depends on the number of employees enrolled and by the level of services required. Most dental plans utilized in Connecticut offer an 80/20 plan, meaning that the plan covers eighty percent of dental costs while the employee is responsible for twenty percent of costs that go beyond the set procedures and protocol that are provided at no charge to the employee.

**•LONG-TERM DISABILITY:**

A regional health district should address the issue of long-term disability. In about fifty-eight percent of Connecticut's regional health districts disability is provided; however, most of these districts have elimination periods ranging from 90 to 180 days. The description of benefits includes percentages of salaries and specific age requirements, such as fifty percent of salary to age sixty-five. Particular policies require the use of all sick and vacation days before disability will take over or be applied.

**•LIFE INSURANCE:**

Most regional health districts provide life insurance policies. The amount provided varies greatly between districts. The majority of regional health districts base the amount of life insurance on employee salaries; others utilize flat base rates which are pre-determined. Several medical plans offer different types of life insurance policies at an additional charge per policy.

**•PENSION (RETIREMENT):**

Seventy-two percent of Connecticut regional health districts have defined contribution plans. The percent that employees contribute towards the pension fund ranges from .0225 to .05. The years of service required for vesting are usually less than five years; however, some districts require ten years. The requirements for normal retirement are based on age and the number of years of service.

A few examples for the normal retirement requirements are as follows:

1. Twenty-five years of service regardless of the employee's age.
2. Employee reaches the age of 65 and has twenty years of service or employment with the same employer.
3. Employee's age and years of employment have to equal or exceed the figure of eighty years.

Early retirement is another factor that needs to be addressed. Policies generally state that the age of fifty-five constitutes early retirement age for employees who have served for twenty years. Pension formulas are unique in almost every situation. The only common formula for Connecticut regional health districts is 1.6% multiplied by the number of years employed if under twenty-five years of service. If the employee has over twenty-five years of service, he or she will receive two percent per

year of employment. This means that for each year of employment the employee will receive 1.6% or 2% of his/her highest three years of salary averaged.

**•UNEMPLOYMENT COMPENSATION:**

Approximately fifty percent of Connecticut regional health districts use the Contribution Method (taxable employer) option where by money is set aside for unemployment funding. The other fifty percent of Connecticut regional health districts function as Reimbursable Employers (self-insured).

**•WORKER'S COMPENSATION:**

Ninety-five percent of Connecticut regional health districts are not self-insured for worker's compensation. These ninety-five percent use CIRMA as a provider. No districts have purchased additional coverage for catastrophic events.

**•MISCELLANEOUS BENEFITS:**

Social Security Taxes (FICA) must be accounted for as well as amortization fees. Furthermore, a district must determine whether to include professional licenses, clothing/car allowances, and tuition reimbursements in its benefit package. These rates are mostly pre-determined. If a regional health district is to attract quality employees, the benefit package may make the difference; therefore, it is of the utmost importance for boards of directors to develop worthy benefits packages and to include and represent these costs in the budget.

**OPERATING EXPENSES**

**•ADVERTISING:**

The advertising portion of the budget encompasses many possible financial responsibilities and avenues. Most of the funds allocated for advertising within a district pertain to announcements and public statements. These costs consist mainly of

copying, paper/material, and distribution costs. Several health districts within Connecticut have cut their advertising costs thanks to local support and services which charge a reduced rate for copier, material, and supply services. Communities often offer backing of material and personnel for educational courses, seminars, discussions on local public health issues and policies, which helps to reduce advertising costs.

A health district must allocate enough funds in the budget to cover emergency events such as vaccine announcements, environmental disasters, and local disease outbreaks. These funds go to newspapers, radio bulletins, and flyers.

**•AUDIT/ACCOUNTING:**

Audit costs are standard for most health districts in Connecticut. The audit costs per Accounting Manager range from \$1,800 to \$3,200. A regional health district must maintain accurate and complete financial records of expenses and all sources of revenue.

**•BOARD/MEETING EXPENSES:**

The expenses of a regional health districts board of directors include:

1. paper/copier costs
2. supplies costs
3. food/beverage expenses
4. telephone expense
5. secretarial services

These expenses must be included in the budget.

**•CLINICAL AND MEDICAL SUPPLIES:**

This item includes laboratory supplies (utilization), medical supplies, health education/materials, and program supplies (ex. influenza programs, hepatitis B programs, immunization programs, and screening programs). In Connecticut,



regional health districts have allocated from \$15,000 to \$25,000 for these supplies, on average.

**•TRAINING/CONTINUING EDUCATION:**

The majority of Connecticut regional health districts contribute, on average, \$3,000 to this expense. A regional health district must maintain current standards for employees and their professional qualifications. Involvement in professional public health organizations and conference attendance is essential. Training for all employees is on-going throughout the year and should not cease. Funds must be provided for training purposes to further educate employees and to meet strict professional standards.

**•CONSULTANT FEES EXPENSES:**

The appropriate functioning of a regional health district requires the services of several types of consultants. These consultants deal in specialized areas and serve as knowledge bases and problem solvers. While the regional health district professionals fulfill their public health missions and responsibilities, outside sources from other fields must also be called upon, as needed. The following is a mention of consultants whom Connecticut regional health districts have sought thus far.

1. legal advisor (Legal services are required by all districts. The amount and extent of services vary from district to district, based on need. However, the basic level of services ranges from \$1,600 to \$2,000.)
2. medical consultant
3. computer consultant
4. financial/management information systems consultant
5. maternal and child health consultant
6. epidemiological services

**•CONTRACT SERVICES:**

A regional health district must determine whether it is able to provide all required services which its population demands. Several regional health districts in Connecticut find it more economical and beneficial to contract services out. If this is the case, then a regional health district must allocate funds in its budget for these services. Examples of contracted services which Connecticut regional health districts have utilized are:

1. custodial services
2. community health (health promotion and disease prevention, communicable disease prevention, surveillance and control, chronic disease prevention)
3. home care programs (skilled nursing, emergency assessment, postnatal program)
4. specimen transportation
5. medical social worker

These costs are pre-determined by the service provided. Negotiations between providers and regional health districts set the wheels in motion for contract terms and policies.

**•MEMBERSHIPS AND PUBLICATIONS:**

A regional health district's employees must keep current in local, regional, and nationwide organizations such as the New England Public Health Association and the Connecticut Public Health Association. This provides professionals with contacts, additional training, communication avenues, and networking opportunities. Various organizations have individual, professional-based membership fees. Therefore, this

expense depends on the number of employees who are involved in the professional organizations and the extent of their professional involvement.

**•FIELD SUPPLIES:**

Field supplies must be accounted for in a regional health district's budget. Field supplies include mileage (travel), field expenses, labs, library costs, and environmental supplies.

**•INSURANCE EXPENSES:**

A regional health district must account for the following insurance fees:

1. auto insurance
2. property insurance
3. worker's compensation insurance
4. bonding insurance
5. liability insurance

Most of these insurance rates are based on six-month or one year policies, and rates correspond accordingly. Each type of insurance needs to be investigated on an individual basis by a regional health district. Insurance is essential for the protection and the proper functioning of a regional health district.

**•MILEAGE/AUTO:**

Automobile and mileage expense varies according to a district's decision on automobile purchase, rental, or lease. A district has the option to purchase vehicles; however, it is then responsible for gasoline, insurance, maintenance, warranties and taxes. Furthermore, the district has to consider depreciation costs and resale values. A district would have to determine whether or not purchasing vehicles would be less expensive than paying an employee's mileage expense or renting or leasing vehicles. On the other hand, the option of renting or leasing a vehicle offers a district reliable

transportation without the hassle of enormous maintenance costs. The district does not have to deal with depreciation costs or resale values. However, on rental and leasing agreements there are often stipulations on mileage requirements. These stipulations could lead to expensive additions to the monthly rental charge. The district would also be liable for vehicle damage if its employee is driving a leased or rented vehicle.

In addition to the above-mentioned options, the option of paying mileage to employees who drive their own vehicles should be considered. This option may be a bit more expensive than others; however, it removes from the district the responsibility for automobile ownership or rental agreements. Under this option, there are no maintenance costs. This option certainly presents the easiest and most convenient way to deal with automobile expense. However, a district that requires extensive automobile travel must weigh the pros and cons and consider the of requiring employees to use their own vehicles.

The following information shows:

Average mileage	* .31	=	example costs for mileage
60,000 (two vehicles)	* .31	=	\$18,600

Example costs for leasing vehicles

Down payment (two vehicles)	\$ 2,000
Vehicle lease (2) Ford Escorts at \$250 each (monthly)	6,000
Fuel (1600 gallons at \$1.37 per gallon)	2,192
Maintenance cost	1,200
(Assumed \$600 each in first year; second year increase due to added costs for tires, tune-ups, brakes, etc.)	
Automobile insurance	3,300
<b>TOTAL</b>	<b>\$14,692</b>

**•OFFICE EQUIPMENT/MAINTENANCE:**

The district's start-up costs for office equipment, will be expensive in the beginning (ranging from \$5,000 to \$7,500); however, leasing of equipment is an option to outright purchase. With a lease agreement, maintenance may be provided in the contract, ensuring that equipment will remain in top condition and function to maximum capacity. Otherwise, repair costs have to be figured into the budgeted amount.

Examples of office equipment include:

- a computer system with software
- a laser printer
- a fax machine
- a copier
- a calculator or adding machine
- office furniture/carpets/safes

**•OFFICE SUPPLIES AND EXPENSES:**

In Connecticut, the average expenditure for office supplies ranges from \$3,000 to \$9,000. The expense varies greatly from regional health district to regional health district, depending on the amount of services provided and the necessary support needed. Printing and postage expenses represent two of the most costly items. Office supplies include stationery, computer paper, pads, pens, pencils, pencil sharpeners, folders, binders, tape, paper clips, envelopes, rubber bands, etc. Most products can be purchased at wholesale costs in bulk.

**•OFFICE SUPPLIES AND EXPENSES:**

A regional health district has many options for this item. First, the Board of Directors must decide on the location of the health district offices. This is a very delicate and important decision involving considerations of cost, convenience, available resources, locality, and space. Once this decision has been made and agreed upon by all participating towns, the board of directors needs to determine whether renting or leasing a property would be more beneficial to the district's functioning and cost outlook. If renting or leasing a property is chosen, it will be necessary to look at the amount of square footage in order to determine cost per square foot. In Connecticut, the average size in square footage space for a health district's offices is 3,219 square feet. The cost per square foot ranges from \$5.00 to \$9.00. A district must consider the rental insurance rates, utility charges (averaging \$3,000 to \$4,000), and maintenance/cleaning fees.

**•TELEPHONE:**

Telephone expense is based on the number of lines used by the district employees and by the number of local and long-distance calls made. In Connecticut, the major phone companies charge a flat rate per business phone line at a standard rate. The more lines needed, the higher the cost. Telephone expense will be less in districts where all participating towns are within the same local calling area. The option of purchasing a toll free number might also be a viable one for districts with distant participating towns. Since a district must also provide twenty-four hour coverage for all phones, pagers and answering machine services will be necessary. Furthermore, the utilization of fax machines and lines must also be accounted for, as well as the cellular phone option if provided. In Connecticut, the telephone expense (calling fees only) for a district ranges from \$2,200 to \$3,300. An all inclusive-

telephone expense-including answering systems, auto phones, fax machines, and beeper services-ranges from \$3,900 for a small district to \$10,500 for a large district.

**•UTILITIES:**

Utilities include electricity expenses, water costs, and heating/air conditioning costs. Factors that determine this expense amount are: (1) the use of oil, gas, or total electric for services; (2) the current rates for each type of power; (3) the amount of services required for functioning; (4) the size of the regional health district's office; and (5) the amount of equipment which requires the services. Rates for each service depend on the regional geographical area and the local charge per time unit for each service. Most Connecticut regional health districts allocate a fixed amount (a range from \$5,000 for a small district to \$11,500 for a large district) for the first year of the functioning of the district and adjust the amount quarterly for budget purposes.

**CAPITAL EXPENDITURES**

**CONTINGENCY:**

This fund is maintained for those events which may occur, however unlikely the probability. Regional health districts allocate a small amount of funds as a safety net for emergency purposes. For the participating towns it makes sense to allow for this fund since it's easier to appropriate funds up front than to go back and ask for more funding.

**REVENUES**

Revenues of a regional health district are mainly generated from the following three sources (Bower, 1995):

- **The State of Connecticut**

Currently, the State of Connecticut allocates \$1.52 per capita based on a population of 5,000 or over for individual member towns. Towns with smaller populations (under 5,000) receive \$1.78 per capita rate. The district is also eligible for a federally funded Preventive Health Block Grant from the state. Once the district has been formed, additional public health grants can be obtained.

- **The participating towns in a regional health district**

As soon as the estimated budget for the district has been proposed and accepted, the contribution from member towns can be estimated. This figure is stated as a per capita rate. Basically, the district would take its total amount for budget, subtract the income from fees and grants, and then divide that remaining figure by the population of the total district.

- **Fees from permits and inspections**

Based on past town performances and rate schedules, districts can determine the estimated revenue from fees for the participating towns in the health district. Examples of the sources for fees are as follows (see Appendix I):

1. licenses
2. soil testing
3. plan review
4. administration reviews
5. permits



6. influenza (med/ed)
7. truck inspection
8. well-drilling tests
9. restaurant/caterer/food store/vendor inspections
10. camp and daycare inspections
11. septic repair/new septic inspections
12. school and nursing home inspections

## **STEP EIGHT:**

### **DRAFT A DISTRICT PROPOSAL**

Sufficient data and information have now been gathered. The steering committee is now prepared with the necessary tools to write a detailed health district proposal for the towns involved. Statutes require that local participating towns have a public hearing to discuss the district option and then to have each town's legislative body vote on joining the new district.

The district proposal is an important document. The proposal is what local town members and officials look at to determine the future of their town's public health resources. The proposal needs to reflect all the passion and dedicated hours of hard work completed by the steering committee along, with a comprehensive and objective analysis of the merits of participating in the district for individual towns. For most town officials, the health district concept will be a new concept in delivering and maintaining public health services. A proposal must familiarize the public with the regional health district concept and with the district's assets that can benefit the participating communities. Good proposals are clear, understandable, and focused. A health district proposal must answer all the reader's questions and must aim at allowing local communities to make informed and objective decisions (The Ledge Light Health District Board of Directors, 1994).

All regional health district proposals are unique to the towns involved in the new regional health district; however, they should all include the following thirteen items which were identified in the North Central District Health Department Proposal:

1. listing of all towns participating in the new district formation process

2. an in-depth description of the health district concept
3. general functions, responsibilities, and structure of a health district
4. proposed health district staffing
5. proposed staff deployment
6. an outline and explanation of the new district's programs, services, and operations
7. an organizational flowchart
8. statement of the results of the local towns needs assessment reports
9. recommendations
10. statement, description, and analysis of identified problems
11. budget options
12. a discussion of the advantages and disadvantages of belonging to a district
13. listing and explanation of relevant statutes and regulations pertaining to health district formation, functioning, requirements, and mandates (North Central District Health Department, 1993).

A subcommittee should be formed to draft the health district proposal. The subcommittee should take into consideration the above-mentioned components of a successful district proposal. It is the duty of the subcommittee to create a user friendly document which is clear, concise, and inclusive. Once the proposal is completed, it should be presented to the steering committee. The steering committee should review and approve a final edition. The proposal is then ready for formal public presentation (see Appendix J).

## CONCLUSION

The health district is a regional approach to the provision of full-time, professional public health services. It is a separate entity of government established under State of Connecticut statutes. The mission is not only to protect the public's health but to improve the quality of life as it relates to public health through health education, promotion, and disease prevention. The health district carries out its statutory mandated responsibilities as stated in the Connecticut Public Health Code. The health district's programs are funded by state operating grants, special grants, town and city contributions and fees collected for licenses, permits, and approvals.

The philosophy of the regional health district is best summarized by the following mission statement of the Institute of Medicine:

The Institute of Medicine defines the mission of public health as fulfilling society's interest in assuring conditions in which people can be healthy. Its aim is to generate organized community effort to address the public interest in health by applying scientific and technical knowledge to prevent disease and promote health. The mission of public health is addressed by private organizations and individuals as well as by public agencies. But the governmental public health agency has a unique function: to see to it that vital elements are in place and that the mission is adequately addressed (Institute of Medicine, 1988).

The success of public health districts in Connecticut demonstrates that towns share common public health needs and that public health services can be delivered efficiently and effectively on a regional basis. The action flowchart for planning a public health district includes the following eight steps:

1. Form a guidance team.
2. Conduct local needs assessment.
3. Form a multi-town steering committee.
4. Review local public health needs assessments. Look for common needs and goals.

5. Review the responsibilities and functions of health districts.
6. Determine district programs, services, and staffing.
7. Develop a budget.
8. Draft a district proposal.

Adhering to these steps will provide a structured and complete method for the planning and formation of a regional health district.

Once these eight steps are successfully completed a new district can be proposed for approval. Then, five actions need to follow in order to activate this new district concept:

1. The district must set up a budgetary appropriation for district membership.
2. A public hearing must be held in each participating town.
3. Each town's legislative body must take a vote (on the resolution or ordinance to form a district).
4. Towns appoint district board members.
5. Once the district board is formed, its members appoint an interim director of health, and the new district becomes operational.

Regional health districts offer a valid option for communities to meet the ever-changing, growing, and demanding public health service needs of Connecticut citizens. These districts continue to improve existing programs while pursuing a regional approach to assessing community needs and developing plans for their proper implementation.

# ***APPENDIX A***

## ***Summary of Health Districts***

### ***Local Health Departments and Health Districts in Connecticut Map***

#### ***Health Districts: A 1995/96 Profile***

***SUMMARY OF HEALTH DISTRICTS***  
***As of July 1, 1995***

<b>ID No. on Map</b>	<b>Name</b>	<b>Constituent Towns</b>
1	Weston Westport Health District	Weston, Westport.
2	Torrington Area Health District	Bethlehem, Cornwall, Goshen, Harwinton, Kent, Litchfield, Morris, Norfolk, Salisbury, Thomaston, Torrington, Warren, Winchester.
3	Naugatuck Valley Health District	Ansonia, Beacon Falls, Derby, Naugatuck, Seymour, Shelton.
4	Northeast Health District	Ashford, Brooklyn, Canterbury, Eastford, Hampton, Killingly, Plainfield, Pomfret, Putnam, Sterling, Thompson, Woodstock.
5	East Shore Health District	Branford, East Haven, North Branford.
6	North Central Health District	East Windsor, Ellington, Enfield, Suffield, Vernon, Windsor Locks.
7	Chesprocott Health District	Cheshire, Prospect, Watertown, Wolcott.
8	Farmington Valley Health District	Avon, Barkhamsted, Canton, Colebrook, East Granby, Farmington, Granby, Hartland, New Hartford, Simsbury.
9	Quinnipiack Valley Health District	Hamden, North Haven, Woodbridge.
10	Bristol-Burlington Health District	Bristol, Burlington.
11	Stafford Health District	Stafford, Union.
12	Pomperaug Health District	Oxford, Southbury, Woodbury.
13	Uncas Regional Health District	Montville, Norwich.
14	Ledge Light Health District	City of Groton, Town of Groton.
15	Newtown Health District	Borough of Newtown, Town of Newtown.
16	West Hartford-Bloomfield Health District	Bloomfield, West Hartford

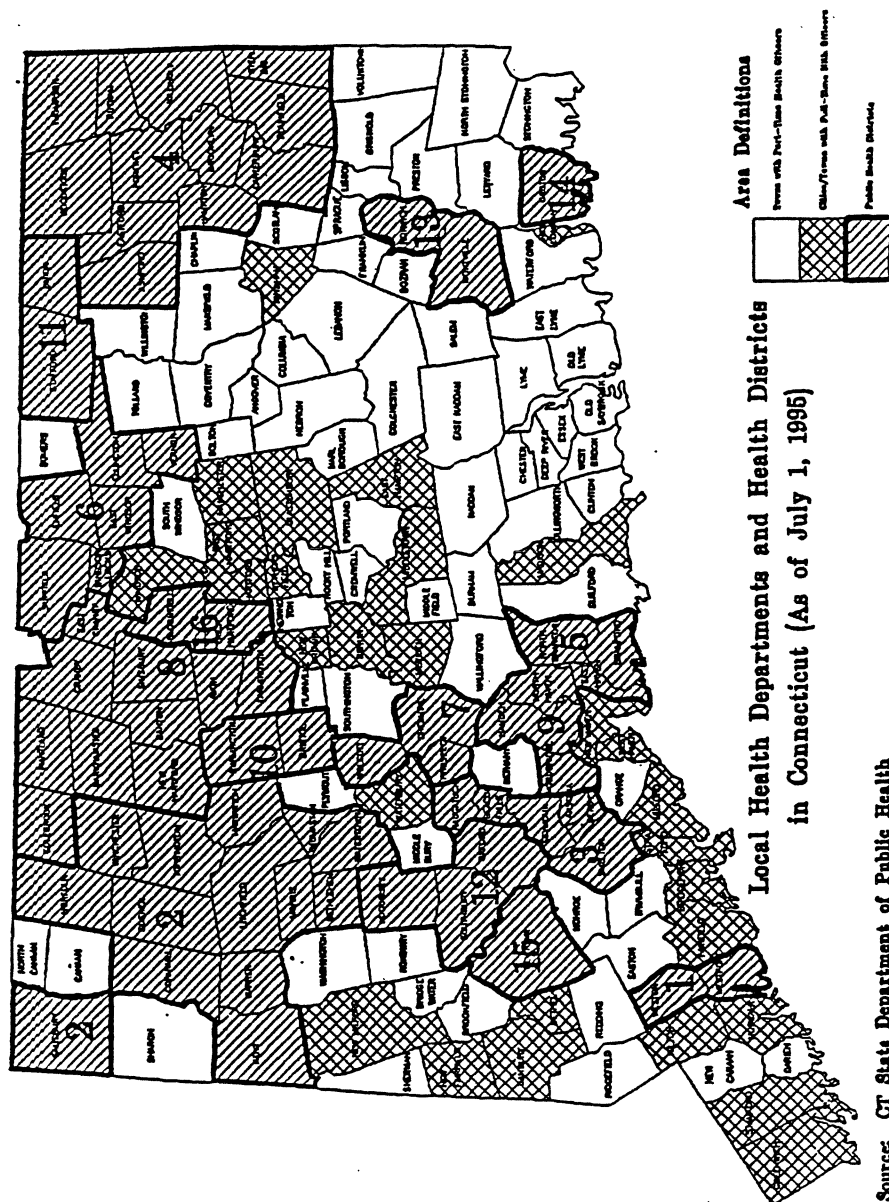
Source: CT State Department of Public Health, 1995.

SUMMARY OF HEALTH DISTRICTS  
FY 1994-95

<u>ID #</u> <u>ON MAP</u>	<u>NAME</u>	<u>DATE</u> <u>FORMED</u>	<u>CONSTITUENT TOWNS</u>
1	Weston Westport Health District	1966	Weston, Westport.
2	Torrington Area Health District	1967	Harwinton, Goshen, Litchfield (Town), Bantam Borough (Litchfield), Litchfield Borough (Litchfield), Morris, Torrington; Cornwall, 12/80; Warren, 1/81; Winchester, 7/83; Bethlehem, Thomaston, 7/87; Kent, Salisbury, 1/88; Norfolk, 3/93; 8/94.
3	Naugatuck Valley Health District	1972	Ansonia, Derby, Seymour, Shelton; Beacon Falls, 7/80; Naugatuck, 4/85.
4	Northeast Health District	1973	Brooklyn, Canterbury, Eastford, Killingly, Danielson Borough (Killingly), Plainfield, Pomfret, Putnam, Sterling, Thompson, Woodstock; Ashford, Hampton, Voluntown, 7/85. Voluntown withdrawal, 7/92.
5	East Shore Health District	1974	Branford, East Haven, North Branford.
6	North Central Health District	1974	East Windsor, Windsor Locks, Ellington, Enfield; Suffield, 7/84; Vernon, 4/93.
7	Chesprocott Health District	1975	Cheshire, Prospect, Wolcott; Watertown, 7/81.
8	Farmington Valley Health District	1976	East Granby, Canton, Granby, New Hartford; Barkhamsted, 7/77; Hartland, 3/80; Simsbury, 5/87; Farmington, 1/92; Colebrook, 4/93; Avon, 5/93.
9	Quinnipiack Valley Health District	1978	Hamden, North Haven, Woodbridge.
10	Bristol-Burlington Health District	1978	Bristol, Burlington.
11	Stafford Health District	1979	Stafford, Stafford Springs Borough (unified, 1991); Union, 10/86.
12	Pomperaug Health District	1986	Southbury, Woodbury; Oxford, 8/89.
13	Uncas Health District	1987	Norwich, Montville.
14	Ledge Light Health District	1993	City of Groton, Town of Groton.
15	Newtown Health District	1994	Town of Newtown, Borough of Newtown.



# HEALTH DEPARTMENTS AND DISTRICTS



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## HEALTH DISTRICTS: A 1995/96 PROFILE

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### Small Health Districts (serving a population under 40,000)

#### **Ledge Light Health District (#14 on map)**

1 Fort Hill Rd.

Groton, CT 06340

Phone: (860) 448-4882

Fax: (860) 448-4885

Director of Health: Mary Jane Engle, MPH, RN

Municipal per capita contribution: \$5.27

Total population served: 34,056

Member towns: 2--Groton, Town (34,056), Groton, City (9,494)

#### **Newtown Health District (#15 on map)**

3 Main Street

Newtown, CT 06470-2104

Phone: (203) 270-4291

Fax: (203) 270-1528

Director of Health: Mark Cooper, MPH, RS

Municipal per capita contribution: \$9.77

Total population served: 20,810

Member towns: 2--Newtown, Town (19,000), Newtown, Borough (1,810)

#### **Pomperaug Health District (#12 on map)**

800 Main St. Suite 130

Southbury, CT 06488

Phone: (860) 264-9616

Fax: (860) 262-1960

Director of Health: Neal A. Lustig, MPH, RS

Municipal per capita contribution: \$5.83

Population served: 33,230

Member towns: 3--Southbury (15,740), Woodbury (8,420), Oxford (9,070)

#### **Stafford Health District (#11 on map)**

Warren Memorial Town Hall

One Main Street

Stafford Springs, CT 06076

Phone: (860) 684-5609

Fax: (860) 684-9845

Director of Health: Bruce D. Lundgren, MPH, RS

Municipal per capita contribution: \$2.84

Population served: 12,280

Towns served: 2--Stafford (11,650), Union (630)

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**Westport Weston Health District (#1 on map)**  
180 Bayberry Lane  
Westport, CT 06880  
Phone: (203) 227-9571  
Fax: (203) 221-7199  
Director of Health: Judith Nelson, MPH  
Municipal per capita contribution: \$13.29  
Population served: 33,570  
Towns served: 2--Westport (24, 610) and Weston (8,960)

**Medium Sized Health Districts (serving populations between 40,000 and 80,000)**

**Bristol/Burlington Health District (#10 on map)**  
240 Stafford Avenue  
Bristol, CT 06010-4617  
Phone: (860) 584-7682  
Fax: (860) 584-3814  
Director of Health: William E. Furniss, MD, MS  
Municipal per capita contribution: \$8.88  
Total population served: 68,000  
Member towns: 2--Bristol (60, 570), Burlington (7,430)

**Chesprocott Health District (#7 on map)**  
1247 Highland Ave.  
Cheshire, CT 06410  
Phone: (203) 272-2761  
Fax: (203) 250-9412  
Director of Health: Thomas Wegrzyn, MPH, RS  
Municipal per capita contribution: \$3.45  
Total population served: 48,280  
Member towns: 3--Cheshire (26,160), Prospect (8,010), Wolcott (14,110)

**East Shore Health District (#5 on map)**  
29C Business Park Drive  
Branford, CT 06405  
Phone: (203) 481-4233  
Fax: (203) 483-6894  
Director of Health: Dennis Johnson, MPH, RS  
Municipal per capita contribution: \$3.40  
Total population served: 48, 280  
Member towns: 3--Branford (28,150), East Haven (26,530), North Branford (13,080)

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**Northeast Health District (#4 on map)**

182 South Main St.

PO Box 145

Brooklyn, CT 06234

Phone: (860) 774-7350

Fax (860) 774-1308

Director of Health: Beth E. Quill, MPH, RN

Total population served: 77,880

Municipal per capita contribution: \$3.00

Member towns: 13--Ashford( 3,920), Brooklyn (6710), Canterbury (4,560) Danielson (B) (4,500), Eastford (1,350), Hampton (1,630), Killingly (11,570), Plainfield( 14,280), Pomfret (3,250), Putnam (8,720), Sterling (2,580), Thompson (8,580), Woodstock (6,230)

**Uncas Regional Health District (#13 on map)**

401 West Thames Street, Unit 601

Norwich, CT 06360

Phone: (860) 823-1189

Fax: (860) 823-1189

Director of Health: not available

Municipal per capita contribution: \$3.25

Total population served: 52,010

Member towns: 2--Montville (16,540), Norwich (35,470)

**West Hartford-Bloomfield Health District (#16 on map)**

50 South Main Street

West Hartford, CT 06107

Phone: (860) 523-3270

Fax: (860) 523-3180

Director of Health: Steven Huleatt, MPH, RS

Municipal per capita contribution: \$5.17

Total population served: 77,450

Towns served: 2--West Hartford ( 58,370) and Bloomfield (19,080)

**Large Health Districts (serving a population over 80,000)****Farmington Valley Health District (#8 on map)**

50 Simsbury Rd.

Avon, CT 06001

Phone: (860) 676-1953

Fax: (860) 676-2131

Director of Health: Richard H. Matheny, Jr., MPH, MFS, RS

Municipal per capita contribution: \$2.90

Total population served: 92,150

Member towns: 10--Avon (14,290), Barkhamsted (3,410), Canton (8,380), Colebrook (1,340), East Granby (4,330) Farmington (21,030), Grandy (9,390), Hartland (1,900) New Hartford (5,970) Simsbury (22,110)

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**Naugatuck Valley Health District (#3 on map)**

470 Howe St.

Shelton, CT 06484

Phone: (203) 924-9548

Fax (203) 924-8308

Director of Health: Leon J. O'Connor, MPH

Total population served: 116,910

Municipal per capita contribution: \$3.50

Member towns: 7--Ansonia (18,130), Beacon Falls (5,260), Derby (12,080), Naugatuck (31,200), Seymour (14,480), Seymour (14,480), Shelton (35,760)

**North Central Health District (#6 on map)**

47 North Main St.

P.O. Box 1222

Enfield, CT 06083

Phone: (860) 745-0383

Fax: (860) 745-3188

Director of Health: William H. Blitz, MPH, RS

Total population served: 121,140

Municipal per capita contribution: \$2.385

Member towns: 6--East Windsor (9,810), Elington (11,600), Enfield (46,010), Suffield (11,350), Vernon (29,950), Windsor Locks (12,420)

**Quinnipiack Valley Health District (#9 on map)**

Chimney Square

1141 Dixwell Ave.

Hamden, CT 06514

Phone: (203) 776-8283

Fax: (203) 785-9272

Director of Health: Leslie Balch, MPH, RN

Municipal per capita contribution: \$5.18

Population served: 81,610

Towns served: 3--Hamden (51,960), North Haven (21,580), Woodbridge (8,070)

**Torrington Area Health District (#2 on map)**

1116 Litchfield Street

Torrington, CT 06790

Phone: (860) 489-0436

Fax: (860) 496-8243

Director of Health: James Rokos, MPH, MS, RS

Municipal per capita contribution: \$2.86

Population served: 106,420

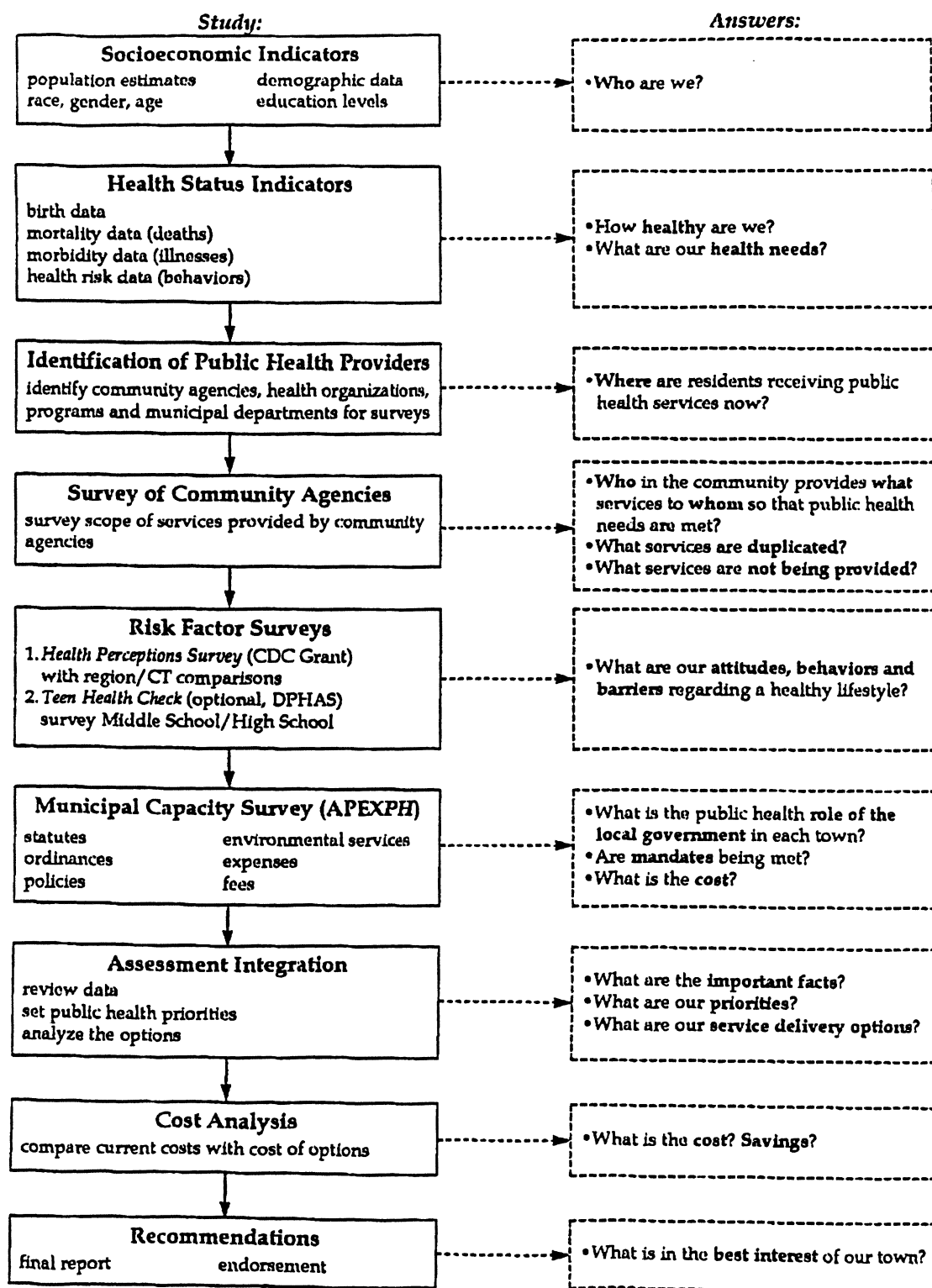
Towns served: 16--Torrington (33,720); Watertown (20,930); Winchester (11,300); Thomaston (7,130); Litchfield, Town (6,287); Harwinton (5,300); Salisbury (4,040); Bethlehem (3,210); Kent (3,040); Goshen (2,410); Morris (2,150); Norfolk (2,080); Cornwall (1,430); Litchfield, Borough (1,394); Warren (1,230); Bantam (769)

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## ***APPENDIX B***

### ***Regional Public Health Needs Assessment Flow Chart***

## Regional Public Health Needs Assessment Flow Chart

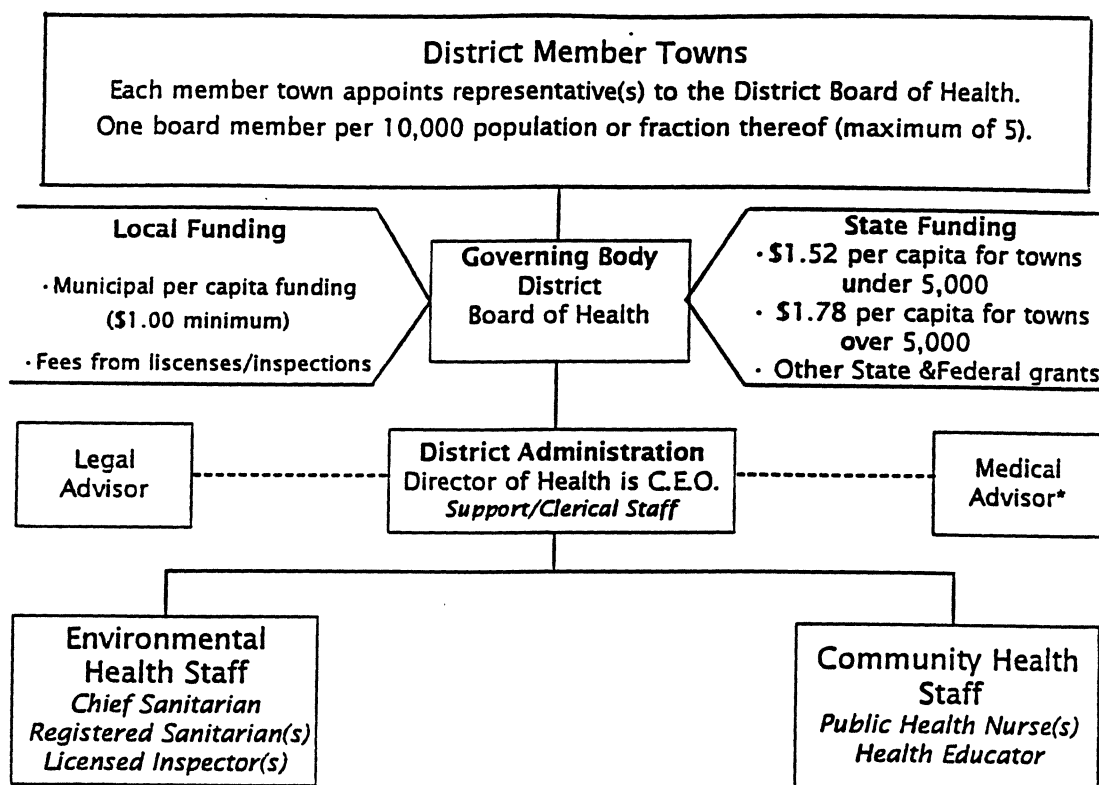


## ***APPENDIX C***

### ***An Organizational Diagram for a Sample Health District***



## An Organizational Diagram for a Sample Health District



\*If the Director of Health is not also a M.D., the district must have a medical advisor, by law.

## ***APPENDIX D***

### ***The Enabling Statutes and Regulations***

## Ch. 368f

## DISTRICT DEPARTMENTS OF HEALTH

vessel so anchored or moored within the limits so designated. Service of notice may be made by any officer or indifferent person by leaving with or reading to the person having immediate charge of any such houseboat or other vessel a copy of this section, together with a description in writing of the limits which have been so designated.

(1949 Rev., S. 3864.)

History: Sec. 19-102 transferred to Sec. 19a-228 in 1983.

**Sec. 19a-229. (Formerly Sec. 19-103). Appeal.** Any person aggrieved by an order issued by a town, city or borough director of health may, within forty-eight hours after the making of such order, appeal to the commissioner of health services, who shall thereupon immediately notify the authority from whose order the appeal was taken, and examine into the merits of such case, and may vacate, modify or affirm such order.

(1949 Rev., S. 3865; P.A. 77-614, S. 323, 610.)

History: P.A. 77-614 replaced commissioner of health with commissioner of health services, effective January 1, 1979; Sec. 19-103 transferred to Sec. 19a-229 in 1983.

Annotations to former section 19-103:

Cited. 174 C. 195, 199.

Cited. 21 CS 347. This section does not apply to appeals under section 7-153. 26 CS 266, 273.

**Sec. 19a-230. (Formerly Sec. 19-104). Fines and penalties.** Any person who violates any provision of this chapter or any legal order of a director of health or board of health, for which no other penalty is provided, shall be fined not more than one hundred dollars or imprisoned not more than three months or both.

(1949 Rev., S. 3875.)

History: Sec. 19-104 transferred to Sec. 19a-230 in 1983.

Annotation to former section 19-104:

Violation of quarantine order within this section. 86 C. 678.

**Secs. 19a-231 to 19a-239.** Reserved for future use.

## CHAPTER 368f

## DISTRICT DEPARTMENTS OF HEALTH

**Sec. 19a-240. (Formerly Sec. 19-105). Definition of "board".** The word "board", as used in this chapter, means a board of a district department of health created as provided herein, unless the context otherwise indicates.

(1949 Rev., S. 3876.)

History: Sec. 19-105 transferred to Sec. 19a-240 in 1983.

**Sec. 19a-241. (Formerly Sec. 19-106). Formation of district departments. Board.** (a) Towns, cities and boroughs, by vote of their respective legislative bodies, after a public hearing, may unite to form district departments of health. The affairs of any such district department of health shall be managed by a board, which shall have all the duties exercised or performed immediately prior to the effective date of the creation of such district by directors of health or boards of health of the municipalities and which shall exercise all the authority as to public health required of or conferred upon the constituent municipalities by law and shall have the powers set forth in section 19a-243. Towns, cities and boroughs may, in like manner, join a district department of health previously formed with the approval of the board of such district.

(b) Each town, city and borough, which has so voted to become a part of any such district, shall, by its board of selectmen, city council or board of burgesses, appoint one person to be a member of such board. Any town, city or borough having a population of more than ten thousand inhabitants, as annually estimated by the department of health services by a method comparable or similar to that used by the United States Bureau of the Census, shall be entitled to one additional representative for each additional ten thousand population or part thereof, provided no such municipality shall have more than five representatives on a district board of health. The term of office for members of the district board of health shall be three years, except that, during the initial formation of the board, appointments shall be so made that approximately one-third of the board shall be appointed for one year, approximately one-third appointed for two years and approximately one-third appointed for three years. Members of the district board of health shall serve without compensation but shall receive their necessary expenses while in the performance of their official duties.

(1949 Rev., S. 3877; 1959, P.A. 236; 1961, P.A. 391, S. 1; 1969, P.A. 527, S. 1; P.A. 77-598, S. 2; 77-614, S. 323, 610.)

History: 1959 act provided for annual estimate of population by state department of health rather than using last-completed U.S. census; 1961 act added description of duties and authority of board, deleted requirement that appointment by municipality be annual, provided for one rather than two appointments per town with additional representation for additional population, limited number of representatives to five and added provisions re length of terms and re reimbursement for expenses; 1969 act made provisions applicable to judges of probate serving at any time during any year after December 1, 1967, rather than to those who were subject to Sec. 45-26 before January 1, 1968, deleted other date references which prevented continued applicability of provisions, required filing of sworn statements by person ceasing to hold office and by personal representative of person who dies while holding office, specified that payments from net income are not deductible from gross income, required successors to incumbents taking office after February first file estimates of annual net income and increased penalty from nine to ten per cent of deficiency amount and interest from six to nine per cent; P.A. 77-598 restated provision re admission of towns, cities and boroughs to previously formed districts, making admission contingent upon board approval rather than upon vote of municipality which formed the district originally; P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-106 transferred to Sec. 19a-241 in 1983.

**Sec. 19a-242. (Formerly Sec. 19-107). Appointment of director of health. Removal. Sanitarians. Authorized agent.** (a) The board shall, after approval of the commissioner of health services, appoint some discreet person, possessing the qualifications specified in section 19a-244, to be director of health for such district, and if he is not selected within sixty days from the formation of any such district, or if a vacancy in said office continues to exist for sixty days, such director shall then be appointed by said commissioner. The board may appoint a person to serve as the acting director of health during such time as the director of health is absent or a vacancy exists, provided such acting director shall meet the qualifications for directors of health in section 19a-244, or such other qualifications as may be approved by said commissioner. Upon the appointment of a director of health under the provisions of this section, the terms of office of the directors of health of the towns, cities or boroughs forming such district shall terminate.

(b) Such director of health may be removed whenever a majority of the directors of such health district find that such director of health is guilty of misconduct, material neglect of duty or incompetence in the conduct of his office.

(c) On and after July 1, 1988, each district health department shall provide for the services of a sanitarian certified under chapter 395 to work under the direction of the district director of health. Where practical, the district director of health may act as the sanitarian.

(d) As used in this chapter, "authorized agent" means a sanitarian certified under chapter 395 and any individual certified for a specific program of environmental health by the commissioner of health services in accordance with the public health code.

(1949 Rev., S. 3878; P.A. 75-573, S. 2; P.A. 77-598, S. 3; P.A. 78-303, S. 66, 136; P.A. 87-521, S. 4; 87-589, S. 48, 87.)

History: P.A. 75-573 added Subsec. (b) re removal of director of health; P.A. 77-598 added provisions re appointment of acting director of health; P.A. 78-303 replaced public health council with commissioner of health services; Sec. 19-107 transferred to Sec. 19a-242 in 1983; P.A. 87-521 added Subsecs. (c) and (d) re sanitarians and authorized agents; P.A. 87-589 moved provision authorizing local director of health to act as sanitarian from Subsec. (d) to Subsec. (c).

See Sec. 19a-201 re contracts with hospitals for provision of director of health by joint action of municipality and district health department.

**Sec. 19a-243. (Formerly Sec. 19-108). Powers and duties of board. Executive committee. Apportionment of expenses.** (a) Each such board may make and promulgate reasonable rules and regulations for the promotion of general health within the district not in conflict with law or with the public health code. The powers of the board shall include but not be limited to the following enumerated powers: To sue and be sued; to make and execute contracts and other instruments necessary or convenient to the exercise of the powers of the health district; to make and from time to time amend and repeal bylaws, rules and regulations; to acquire real estate; and to have whatever other powers are necessary to properly carry out their powers as an independent entity of government.

(b) The board shall meet at least quarterly and at other times determined by the chairman. At its September meeting it shall elect a chairman and it shall furnish the necessary offices and equipment to enable it to carry out its duties. The board may elect an executive committee, consisting of the chairman and two other members, and the director of health, who shall serve without a vote, and such executive committee shall have power to act when the board is not in session. The fiscal year of each district department of health shall be from July first to June thirtieth, and, by June thirtieth in each year, the board shall estimate the amount of money required to pay the costs and expenses of the district during the ensuing fiscal year, provided, if any municipality within the district has a fiscal year which begins on July first, such estimate shall be made by April thirtieth of each year. Such board shall hold a public hearing on its proposed budget, two weeks' notice of which shall be given in a newspaper having a circulation in each constituent municipality of such district. From time to time the board shall draw upon the treasurer of each town, city or borough within the district a proportionate share of the expenses of such district, from such funds as may have been appropriated by each, to pay the cost of operating the district, such apportionment to be made equitable on a per capita basis as established by the last annual population estimate by the department of health services for each participating town, city or borough.

(1949 Rev., S. 3879; 1961, P.A. 391, S. 2; 1969, P.A. 527, S. 2; 688, S. 1; 1971, P.A. 178; P.A. 77-614, S. 323, 610; P.A. 92-3.)

History: 1961 act specified chairman's election be in September, deleted requirement that board determine relative amount of service to be performed in each municipality, added provisions re promulgation of rules and regulations, board meetings and executive committee, provided that board draw proportionate share of expenses of each district, that such apportionment be made on a per capita basis rather than on the basis of average receipts for the preceding three months and deleted provisions authorizing departments to use additional funds secured from federal or official agencies and to disburse money so received; 1969 act divided section into subsections, moved provision re election of chairman and re offices and equipment into Subsec. (b), enumerated various powers of board, required quarterly meetings rather than annual meetings in September and specified that director of health has no vote; 1971 act required budget estimates be made during April if a municipality in the district has fiscal year beginning on July 1 and added provision re public hearing on budget; P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-108 transferred to Sec. 19a-243 in 1983; P.A. 92-3 amended Subsec. (b) to require budget estimates for the health districts by June thirtieth instead of during June and, if any municipality within the district has a fiscal year beginning July first, by April thirtieth instead of during April.

See Secs. 7-425 et seq. for duties re retirement of employees.

See Sec. 12-146a re authority to revoke license or permit to do business for an enterprise which has failed to pay personal property taxes.

See Sec. 19a-245 re funds received from state and federal sources.

**Sec. 19a-244. (Formerly Sec. 19-109). Qualifications, term and duties of director of health. Employees.** The director of health shall either (1) be a doctor of medicine and hold a degree in public health as a result of having at least one year's special training in public

health, or, in lieu of said degree, shall meet the qualifications prescribed by the commissioner of health services, or (2) be trained in public health and hold a masters degree in public health. The board may specify in a written agreement with such director the term of office, which shall not exceed three years, salary and duties required of and responsibilities assigned to such director in addition to those required by the general statutes or the public health code, if any. He shall be removed during the term of such written agreement only for cause after a public hearing by the board on charges preferred, of which reasonable notice shall have been given. He shall devote his entire time to the performance of such duties as are required of directors of health by the general statutes or the public health code and as the board specifies in its written agreement with him; and shall act as secretary and treasurer of the board, without the right to vote. He shall give to the district a bond with a surety company authorized to transact business in the state, for the faithful performance of his duties as treasurer, in such sum and upon such conditions as the board requires. He shall be the executive officer of the district department of health. Full-time employees of a city, town or borough health department at the time such city, town or borough votes to form or join a district department of health shall become employees of such district department of health. Such employees may retain their rights and benefits in the pension system of the town, city or borough by which they were employed and shall continue to retain their active participating membership therein until retired. Such employees shall pay into such pension system the contributions required of them for their class and membership. Any additional employees to be hired by the district or any vacancies to be filled shall be filled in accordance with the rules and regulations of the merit system of the state of Connecticut and the employees who are employees of cities, towns or boroughs which have adopted a local civil service or merit system shall be included in their comparable grade with fully attained seniority in the state merit system. Such employees shall perform such duties as are prescribed by the director of health. In the event of the withdrawal of a town, city or borough from the district department, or in the event of a dissolution of any district department, the employees thereof, originally employed therein, shall automatically become employees of the appropriate town, city or borough's board of health.

(1949 Rev., S. 3880; 1969, P.A. 688, S. 2; 1971, P.A. 183; P.A. 78-303, S. 67, 136; P.A. 79-85; P.A. 82-8.)

History: 1969 act replaced statement that necessary assistants and clerks be appointed subject to approval of board with specific provisions re personnel of city, town or borough health departments as employees of district health department and deleted provision that compensation be fixed by the board; 1971 act permitted health director to be "trained in public health and hold a master's degree in public health" as alternative qualification; P.A. 78-303 replaced public health council with commissioner of health services; P.A. 79-85 added provision re written agreement with director setting term of office and duties in addition to those required by state law or public health code; P.A. 82-8 specified that district health departments must hire full-time employees of town, city or borough which joins or forms the district department where previously part-time employees were included by implication through use of term "personnel" without reference to type of employment; Sec. 19-109 transferred to Sec. 19a-244 in 1983.

**Sec. 19a-245. (Formerly Sec. 19-110). Reimbursement by state.** Upon application to the state department of health services, each health district shall quarterly receive from the state an amount equal to forty-four and one-half cents per capita for each town, city and borough of such district which has a population of five thousand or less, and thirty-eight cents per capita for each town, city and borough of such district which has a population of more than five thousand, provided (1) the commissioner of health services approves the public health program and budget of such health district and (2) the towns, cities and boroughs of such district appropriate for the maintenance of the health district not less than one dollar per capita from the annual tax receipts. Such district departments of health are authorized to use additional funds, which the department of health services may secure from federal agencies or any other source and which it may allot to such district departments of health. The district treasurer shall disburse the money so received upon warrants approved by a majority of the board and signed by its chairman and secretary. The comptroller shall

quarterly, in July, October, January and April, upon application as aforesaid and upon the voucher of the commissioner of health services, draw his order on the treasurer in favor of such district department of health for the amount due in accordance with the provisions hereof and under rules prescribed by said commissioner. Any moneys remaining unexpended at the end of a fiscal year shall be included in the budget of the district for the ensuing year. This aid shall be rendered from appropriations made from time to time by the general assembly to the department of health services for this purpose.

(1949 Rev., S. 3881; 1963, P.A. 508; P.A. 77-614, S. 323, 610; P.A. 78-251, S. 1, 2, 7; 78-303, S. 68, 136; P.A. 85-421, S. 2, 3; P.A. 87-414, S. 2, 3.)

History: 1963 act provided for reimbursement to health district instead of constituent municipalities, made state's payment quarterly instead of annually in June, deleted provision that sums received be one-half those actually paid and limits of four thousand dollars per town and twenty thousand dollars in the aggregate, and added provisions that amount received be twenty-five cents per capita, limited maximum amount received by district annually to one hundred thousand dollars, added provision re additional funds from federal agencies or other sources and provided for disbursement of money upon warrants approved by board majority and signed by chairman and secretary; P.A. 77-614 replaced commissioner and department of health with commissioner and department of health services, effective January 1, 1979; P.A. 78-251 increased per capita amount received from twenty-five to thirty cents contingent upon approval of public health program and budget by commissioner, increased maximum amount received to one hundred twenty thousand dollars, removed limit on additional funds of amount equal to one-half the total district budget and, in conjunction with P.A. 78-303, referred to rules prescribed by commissioner rather than by public health council; Sec. 19-110 transferred to Sec. 19a-245 in 1983; P.A. 85-421 increased quarterly per capita payments to health districts from thirty cents to (1) forty-two and one-half cents for each town, city and borough of a district which has a population of five thousand or less and (2) thirty-two and one-half cents for each town, city or borough of a district which has a population of more than five thousand and increased maximum annual payment to a district from one hundred twenty thousand to one hundred forty-five thousand dollars; P.A. 87-414 increased the per capita payments to forty-four and one-half cents per capita and thirty-eight cents per capita on basis previously established and deleted the annual cap on payments to districts.

**Sec. 19a-246. (Formerly Sec. 19-111). Withdrawal from district.** Any constituent town, city or borough may, by vote passed prior to January first in any year, withdraw from the district, such withdrawal to become effective on the first day of July following, provided such city, town or borough shall have been a member of the district for at least twenty-four months prior to such vote of withdrawal. A city, town or borough on withdrawal shall at once resume such status with respect to the appointment of its director of health, employees and board of health as it held prior to becoming a member of the district as provided in section 19a-244. Employees shall not lose any benefits or civil services status as a result of the withdrawal from the district.

(1949 Rev., S. 3882; 1961, P.A. 391, S. 3; 1969, P.A. 688, S. 3.)

History: 1961 act provided that vote for withdrawal be prior to January first rather than April first, required membership for at least twenty-four months prior to vote or withdrawal and provided that town, city or borough resume status "with respect to the appointment of its director of health and board of health" as it held prior to district membership; 1969 act included references to status re appointment of employees and added provision protecting benefits and civil service status of employees; Sec. 19-111 transferred to Sec. 19a-246 in 1983.

**Secs. 19a-247 to 19a-249. Reserved for future use.**

## CHAPTER 368g

### LUNG DISEASE, TUBERCULOSIS AND OTHER CHRONIC ILLNESS

**Sec. 19a-250. (Formerly Sec. 19-112a). Definitions.** As used in this chapter, "chronic illness" means conditions which require prolonged definitive hospital or restorative care as distinguished from diseases or conditions which may be properly cared for in convalescent, custodial or domiciliary facilities, and "chronic disease hospital" means a hospital operated by the department of health services.

(P.A. 76-139, S. 3; P.A. 77-614, S. 323, 610.)

History: P.A. 77-614 replaced department of health with department of health services, effective January 1, 1979; Sec. 19-112a transferred to Sec. 19a-250 in 1983.

IMPORTANT: Read instructions on back of  
 Connecticut State forms carefully and  
 Failure to comply with instructions  
 may result in refusal to process  
 application.

STATE OF CONNECTICUT  
 REGULATION

OF

Effective December 15, 1993

ATTACHMENT 8

Page 1 of 2

NAME OF AGENCY

Department of Health Services

Commissioner

SUBJECT MATTER OF REGULATION

19a-76-1 thru State Financial Aid for Local Health Departments

SECTION 19a-76-4

The regulations of Connecticut state agencies are amended by adding sections 19a-76-1 to 19a-76-4, inclusive, as follows: (NEW)

Section 19a-76-1. DEFINITIONS

- (a) "Full-time local director of health" or "director" means a municipal or district director of health who is responsible for enforcing public health laws and administering public health programs; and is employed on a full-time basis by a district or municipality.
- (b) "Health department" means the municipality or district unit which is administered by the full-time local director of health.
- (c) "Commissioner" means the Commissioner of the State Department of Health Services.

Section 19a-76-2. BASIC LOCAL HEALTH PROGRAM

- (a) To be eligible for state grants under section 19a-202 or section 19a-245 of the Connecticut General Statutes, health departments shall ensure the provision of a basic public health program in accordance with subsection (b) below. The health department may ensure the provision of a program by directly providing the service, contracting with another health department or community agency or coordinating public health services with other community or regional resources providing specialized services. Nothing in these regulations shall prohibit any health department from providing health services in addition to the basic services described in subsection (b) below.
- (b) The basic health program to be provided shall include the following services that prevent disease or reduce conditions that have an adverse effect on health:
  - (1) Public Health Statistics. There shall be participation in a mechanism for the collection, tabulation, analysis and reporting of public health statistics for the health jurisdiction served;
  - (2) Health Education. There shall be public and professional information and education with emphasis on prevention and individual responsibility for health status, community organization and outreach;



STATE OF CONNECTICUT  
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19a-75-1 thru  
19a-75-4  
SECTION

NAME OF AGENCY  
Department of Health Services

- (3) Nutritional Services. There shall be a nutrition program including appropriate activities in education and consultation for the promotion of positive health, the prevention of ill health, and the dietary control of disease;
- (4) Maternal and Child Health. There shall be a comprehensive plan for maternal and child health services to include but not necessarily be limited to:
  - (A) prenatal, childbearing, and reproductive care;
  - (B) family planning;
  - (C) child and adolescent health including school health;
  - (D) child abuse;
  - (E) genetic disease control;
- (5) Communicable and Chronic Disease Control
  - (A) There shall be preventive services including immunization, screening, consultation, diagnostic services, epidemiological investigation, and community education;
  - (B) The qualifying health department shall identify resources and provide referral for treatment and rehabilitation of persons with communicable, chronic, and handicapping conditions including, but not necessarily limited to, tuberculosis, venereal disease, cancer, hypertension, and cardiovascular disease;
  - (C) There shall be a plan for the prevention and control of vision, hearing, and dental problems;
- (6) Environmental Services. These shall include activities relating to water, food, air, wastes, vectors, housing, bathing places, safety, noise, toxic hazards, and nuisances in the community and work place;
- (7) Community Nursing Services. There shall be provision for community nursing needed to implement programs for which the qualifying health department is responsible;
- (8) Emergency Medical Services.  
There shall be provision for the development and implementation of an emergency medical service system to include: identification of primary services, written mutual aid and mass casualty plans, and participation in regional planning.

## ***APPENDIX E***

### ***Worksheets for Step Six: Determining District Programs, Services and Staffing***

## WORKSHEETS FOR DETERMINING DISTRICT PROGRAMS, SERVICES AND STAFFING

### Services

Area	District provides OR district subcontracts OR menu option	Specific services/ Specific programs	Staff required— New or transfer from existing departments?
Public health statistics/ Health planning			
Health education			
Nutrition services			
Community nursing services*			
Maternal and child health services			
Communicable and chronic disease control			
Emergency medical services Emergency preparedness			

\* Options for this service area include 1) towns can contract directly for services with nursing services (i.e., VNAs), 2) districts can employ staff to provide services directly, 3) districts can subcontract nursing services or 4) a menu approach can be used (district provides nursing services to some member towns and not others).

### Determining Health District Environmental Services

Regulatory area	DPH guidelines	Programs/Services	Staff
On-site sewage disposal	Soil testing, site investigation, review plans, work with citizens, consultants & other agencies, issue permits, approvals for septic systems & subdivisions.		
Food services	Quarterly inspections, review plans for new/remodeled establishments, disease surveillance, outbreak investigations, license/permits or register food establishments.		
Water supply	Coordinate public water supply activities with DPH, issue private well permits, review water analysis reports.		
Lead	Perform epidemiological investigations in reported elevated blood lead cases, review abatement projects.		
Radon	Provide guidance in elevated air/water radon sites, coordinate abatement with DPH.		

**Environmental health continued...**

Regulatory area	DPH guidelines	Programs/Services	Staff
Asbestos	Coordinate response to complain about abatement projects in schools, public and private buildings with DPH.		
Housing	Respond to various housing concerns including nuisances, garbage, refuse, mobile home parks, abandoned property, etc.		
Recreation	Inspect all public pools, public housing areas, sample bathing water & review samples.		
Vector control/ rabies	Respond & resolve complaints involving mosquito breeding areas, rat infestation, bats, etc. Coordinate with DPH & animal control officer to identify rabid animals and human health response.		
Shellfish monitoring	Coordinate & assist the Dept. of Agriculture in determining shellfish closure through sanitary surveys.		
Institutional inspections (day care, infirmaries, schools)	Conduct pre-license inspections regarding water supply, adequate septic, food services, etc.		

**Environmental health continued...**

Regulatory area      DPH guidelines      Programs/Services      Staff

General complaints	Respond quickly to general air, water, soil and other various complaints.		
Emergency health responses	Develop procedures to coordinate with all state, local and federal agencies in response to natural disasters, food recalls, toxic spills, etc.		

## ***APPENDIX F***

### ***Budgeting for a Proposed Health District***

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## *The Budgeting Process*

As the budget process depends on many factors that can differ between districts, the concepts presented in this section will be described in general terms. Within these generalities, a district can develop a budgeting process that meets its individual need.

A district budget will cover the costs of the **support function** and the **program function**. The support function is responsible for the management of the district. The support function is the administrative arm of the district. Responsibilities include the establishment of the district program of services, finding funding to support the district program, and advertising the availability of program services. The program function is responsible for the on-going operations of the program services.

A budget is a **plan of action**. The plan of action for a district is the activities necessary to successfully complete the services included in its program. This plan of action is first expressed in nonmonetary, then in monetary terms. When offering services, the first step is to estimate what services will be demanded within the district and how many customers will want the services. This is a budget expressed in quantities, and is very difficult to estimate in the first year in operation. However, without this estimate, the plan of action can not be expressed in monetary terms.

The program planning process selects the services to be provided by the district and develops the district's goals. The activities necessary to perform the services help the district to achieve its goals. The budgeting process fine tunes the nonmonetary budget as the monetary needs to achieve the planned program are determined. The basis for the monetary budget is the estimated available resources to complete the program; this is called the **spending ceiling**. As expenditures to achieve the program are estimated, revisions to services and activities are altered to fit within this ceiling. Otherwise, the district will run out of funds. This is called a **shortage** or **short fall**.

To help control operating costs, separate budgets are prepared for the support and program functions. Budgets prepared for each service within the planned program are consolidated and establish the program function budget. *Exhibit 1* is an example of a Service Activity Budget. *Exhibit 2* consolidates *Exhibit 1* information.

Separate budgets for administration of the district affairs and the fund raising activities are combined into the administrative budget or the support function budget. The support function is an overhead cost which can be funded in several ways. The basic budget format presented in *Exhibit 3* assumes funding comes from the services budgets. Modify the basic format to represent your district funding source.

The budget for the agency as a whole is called a **master budget**. See *Exhibit 4*. The master budget includes data from the program budget, the support budget and, if relevant, the **capital budget**.

The capital budget lists and describes planned purchases of property and equipment which will be used over a period of two or more years. These capital assets are necessary for the district to achieve its program. Generally Accepted Accounting Principles and various other external regulatory entities require an established capitalization policy and maintenance of a capital asset inventory. This ensures consistent treatment of like assets, comparability of financial statements from one period to another, and establishes guidelines for the purchase of high ticketed items. For example: the policy can state that all equipment purchases over \$5,000 that will be used for 2 or more years must be budgeted through the capital budget and depreciated over the useful life of the asset. The pol-

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icy should take into consideration individuality and size of the items and the feasibility of control. Modifications to the policy are made when warranted.

The **cash flow budget** summarizes the planned inflow and outflow of cash and helps minimize the chance of a cash shortage. It highlights months when an alternative source of funds may be necessary. This is important because it is always easier to get a promise of help when you are not in dire need. *Exhibit 5* shows a cash flow format.

The capital budget is derived from decisions made during the program planning process and the cash flow budget is derived from the service operating budgets and the capital budget. Budget formats vary and are designed to meet the needs of individual organizations. In some cases, budget formats presented to funding sources must follow special guidelines. If these guidelines are not followed, funding may be withheld without the request even being evaluated. It is important to identify these cases prior to the budgeting process so that a computer program can be developed to transfer data to the required format. This eliminates the need for restatement before submitting the request.

In a not-for-profit setting, the budget submitted to supporting organizations with the request for funding usually needs to be adjusted after funding is determined. Developing good program planning skills and grantsmanship helps minimize such adjustments.

## ***APPENDIX G***

***Westport Weston Health District Budget Presentation FY 96***

WESTPORT WESTON HEALTH DISTRICT  
BUDGET PRESENTATION  
FY 96

MISSION:

The mission of local Health Districts is to preserve public health, prevent the spread of disease, promote wellness and enforce state health statutes, the Public Health Code and local ordinances and sanitary codes.

I. Agency Summary and Authority

The Westport Weston Health District (WWHD) is one of fifteen local Health Districts in the State of Connecticut. Established on July 1, 1966, it serves the Towns of Westport and Weston, with a total population of 33,570.

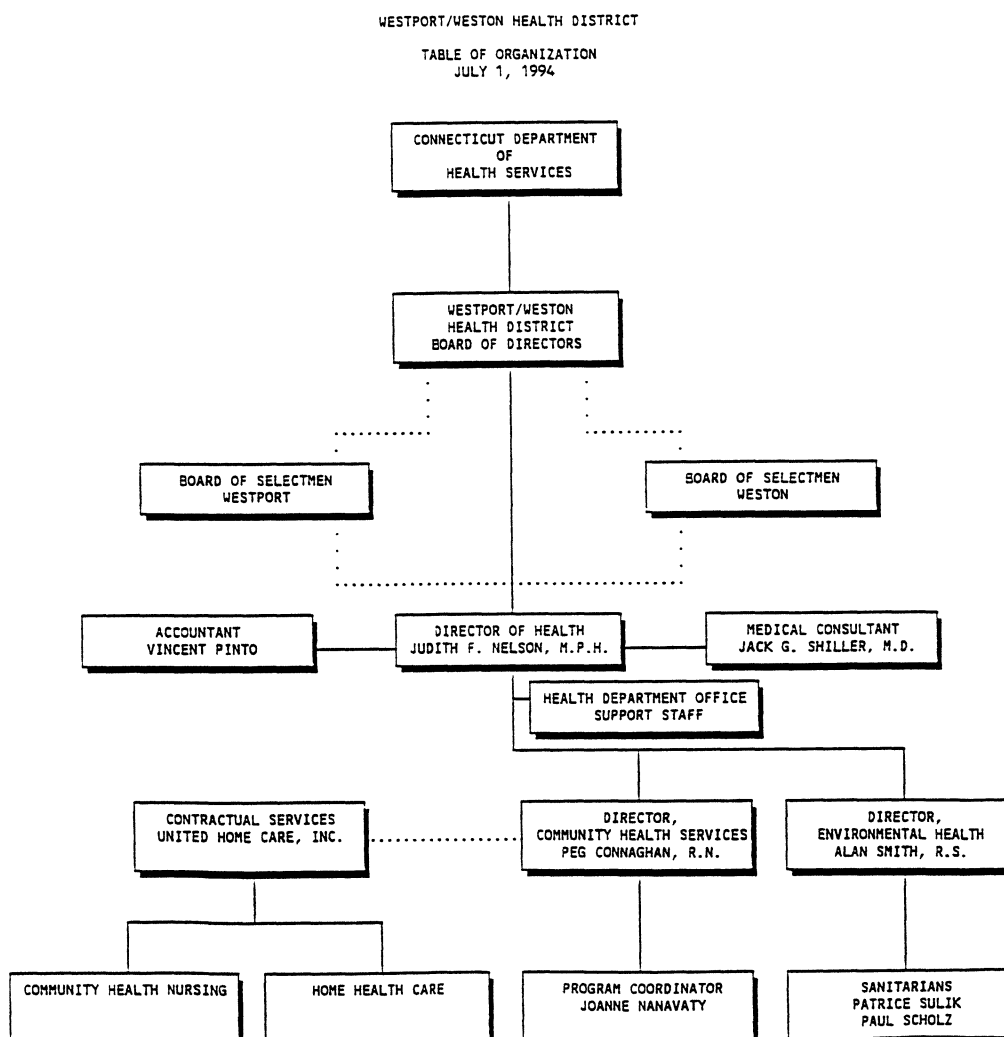
The District is a governmental entity authorized under Connecticut statutes for the purpose of providing local public health services. The governing authority is by a Board of Directors and the Director of Health acts as a delegated agent of the State Commissioner of Public Health for the purposes of enforcing the Public Health Code.

District services include regulatory activities in the area of environmental health, including septic system inspection and approval; well and water quality monitoring; food service, cosmetology, barber shops and public pool licensure; lead investigations; radon, beach and public pool monitoring, and public health complaint investigations. Preventing epidemics is a critical service which includes immunization programs for children, adults and first responders; disease surveillance, and outbreak investigation. The District has an expanded program of health promotion and educational activities on varied public health topics that affect Westport and Weston residents. One of the core functions of public health is to promote healthy behaviors.

Data collection, analyses and health planning activities are another core public health function. A strategic plan for the Health District has been developed and will guide the focus of the District's resources and efforts in the future. The District provides some direct clinical services in clinics and in the home and plans to expand this clinical program to better link higher risk residents to needed services at the District or to facilitate accessibility to health care in the community.

In order to qualify for the Per Capita Grant from the State, the local health district must ensure the provision of core public health programs, as defined by the State.

## II. Organizational Table:



### III. Critical Community Needs:

The Health District's Board of Directors continues to evaluate the District's programs in light of our community's needs and has identified the following critical needs of the Westport Weston community.

1. The aging population is increasing the need for health care intervention.
2. Industry downsizing is eroding traditional benefits/security.
3. Increased health care costs resulting in reduction of insurance coverage by employers with higher deductibles and more limited coverage.
4. Many middle-aged and elderly people do not take initiatives to provide proper self-help.
5. Elderly population vulnerable to one-time or irregular health risks such as pneumococcal pneumonia or flu.
6. Significant segment of population either cannot afford or are uninsured for necessary periodic health maintenance assistance in monitoring changes or deterioration of health.
7. Pre-school age children receiving less health care attention due to the increasing need for full-time employment of both parents resulting in less time to obtain preventive health care. With the lack of discretionary funds, underinsurance causes lags in attention to pre-schoolers' immunization health screening needs.
8. Postpartum mothers and their infants receiving less care and instruction in the hospital, as postpartum stays become shorter. Underinsureds not monitored in the home during critical neonatal period.
9. Growing incidence of unintentional injuries in young adults and elderly.
10. Increasing substance abuse expanding exposure to violence/unintentional injury/disease.
11. High exposure of HIV/Sexually Transmitted Diseases (STD). Over 50% of adolescents sexually active; risk enhanced by substance abuse.

12. Increasing numbers of skin cancer being diagnosed annually, and screening not covered by Medicare. There is some reluctance to visit physicians due to cost or irrational fear of high probability of confirmation.
13. Uncontrolled diabetes contributes to cardiovascular disorders. Eighty percent of diagnosed diabetes cases do not receive adequate education about the disease and how to control it; half of those afflicted are either unaware or ignore.
14. Continuing Rabies epidemic and some reluctance to pay to inoculate household animals.
15. High exposure to Lyme Disease affects life style and, for the Health District, environmental decisions. Other vector-borne diseases emerging from rats, mosquitoes and ticks.
16. Westport has a disproportionately large number of commercial dining facilities creating a sensitive need for monitoring adherence to Westport Weston Health District and State sanitation regulations.
17. Increasing concern for the quality and adequacy of the private water supply and the potential for contamination from fuel tanks, pesticides, salt run-off, radon, etc.
18. Increasing work-related illness/injury necessitating education of primary care providers and employers.

#### IV. BOARD OBJECTIVES:

The Board has adopted an exceptionally progressive set of objectives to deal with the communities' unresolved emerging health issues with a mission and an agenda that constructively exceeds those normally associated with health districts:

1. Providing unmet support services for segments of the population including the older population with homebound chronically ill and young families with early discharge mothers and babies.
2. Providing proactive environmental risk assessments.
3. Enhancing preventive/proactive health activities.
4. Contributing to lowering of medical costs.
5. Providing access to health care services to the medically underserved.
6. Providing informative, counseling and comforting services to those whose behavioral patterns have or may threaten their health.

#### KEY PROGRAMS, FY 95

1. Expansion of childhood immunization program to include more children. at reduced or no cost. (Federal *Vaccine for Children* Program).
2. Initiation of home-based, post-natal program to provide assessments and instruction to early discharge mothers and their infants in need of services.
3. Expansion of a public communication plan to promote the Health District Services to the underserved or underinsured community, through the media, brochures, recorded information line, newsletters and calendars.
4. Deletion of on-site screening and immunization program for community groups (employers, clubs, churches). Marginal interest from community.

5. New compensation and fringe package to bring compensation and career paths to competitive levels.

#### KEY PROGRAMS, FY 96

New initiatives consistent with the long range objectives will be phased in over the next several years. In FY 96, the effort is focused on the expansion of existing services in the nursing program and the reassessment of services in environmental health. While the District will experience some cost recovery for the expanded programs, the overall impact will be an increase in the Towns' contribution which has been minimized in the past through application of the Fund Balance. A large Fund Balance is less likely to occur in the future.

In FY 96, key programs to be added or modified include:

1. Expansion of the daily clinic, which provides immunizations, screenings and counseling to include adult and childhood physical examinations, at some cost recovery.
2. Expansion of home-based, post-natal program to provide assessments and instruction to early discharge mothers and their infants in need of services.
3. Expansion of services (laboratory and physical examinations) in the periodic screening clinics to include diabetes, colorectal cancer, prostate cancer and SPA, breast cancer, uterine cancer, testicular cancer, glaucoma, at some cost recovery.
4. Modification of the Food Service Inspection Program to a risk-based protocol, with a more intense inspection and education program for substandard establishments.
5. Addition of an unintentional injury prevention program for public playground construction and monitoring.



Fund Balance:

The Fund Balance on June 30, 1994 was \$247,326, of which \$13,992 was restricted to support computerization of the Food Service Program from the FY 94 Per Capita Grant. Of the balance, \$80,301 supported the FY 95 Budget.

There is no provision for a Capital Improvements Budget for replacement of computer equipment and building systems, or for self-insured liability.

DISTRICT BUDGET (04-10) EXPENDITURESSalary and Fringe Changes:

1. Assistant to Health Director. 0.50 FTE  
Position Reclassified from Sanitarian II, 0.50 FTE

This position will assist the Director of Health, primarily in the area of environmental health. Administrative responsibilities will include budget budget monitoring, annual report, development of a revised user fee schedule, development of a plan review protocol for food and cosmetology establishments. Requires knowledge of local health administration and public health.

FY 95 Budget	\$23,900
FY 96 Budget	\$25,900
<u>Budgeted for an additional</u>	<u>\$1,100</u>

2. Community Health Director  
Sanitarian II -

FY 95 budgeted salaries were not competitive for the education and experience required for the positions which were vacated in FY 94.

FY 95 Budget	\$88,629
FY 96 Budget	\$100,000
<u>Budgeted for an additional</u>	<u>\$11,371</u>

3. Clerk Typist/Receptionist -

Promotion based on merit performances.

FY 95 Budget	\$24,247
FY 96 Budget	\$26,000
<u>Budgeted for an additional</u>	<u>\$1,753</u>

## DISTRICT BUDGET (04-10) REVENUE:

### State Per Capita Grant:

The State Per Capita Funding (\$1.52/per capita) was preserved in the State Department of Public Health and Addiction Service (DPHAS) Budget, and it is anticipated that this level of funding will be maintained. The population of Westport Weston is  $33,570 \times \$1.52 = \$51,026$ . Westport's contribution to the population is 74% and Weston's contribution is 26%, based on population estimates. The State population projections appear to be lagging actual population growth, which the Health District will challenge with the Town's support.

This Grant supports the Community Health Director in the development and monitoring of programs in health promotion, disease prevention and home care, upgrading the computer system for food service and the Sanitarian II position.

### Fees:

#### 1. Environmental Programs -

Environmental Health Permits are the major source of fees. Based on FY 94 actual revenue (\$152,000), mid-year projections, and a user fee increase, total revenue from environmental health permits for FY 96 is projected at \$175,000. Revenue from this source tends to fluctuate depending on turnover of restaurants and subdivision development.

#### 2. Nursing Programs -

A daily nursing clinic was introduced in FY 94 and was to be expanded in FY 95 to an enhanced clinical program, utilizing a family nurse practitioner. Due to turnover of personnel and the uncertainty of Health Care Reform and its impact on primary care in a local public health department, the implementation was postponed to FY 96. Revenue is projected at \$16,000 for FY 96, based on the experience of other programs.

Periodic, more affordable and expanded immunization and servicing clinics are budgeted to generate revenue of \$23,000 for immunization and \$4,000 for screenings.

### 3. Home Care Programs

The direct provision of nursing care is provided by a voluntary nursing agency, under contract with Westport Weston Health District. The services have included emergency assessment, care of the chronically ill and care of the sick. Criteria for admission were established in 1990. A sliding scale has been instituted for the home care programs.

#### Expanded Post Natal (Family) Home Care Program

To provide post partum and newborn monitoring and supervision to high risk families or new mothers within 24-48 hours of delivery because of reduced hospital stays and lack of post natal instructions.

FY 95 Budgeted at	\$ 1,750
FY 96 Budgeted at	\$ 5,520
<u>Budgeted for additional</u>	<u>\$3,770</u>

Summary of Community Health and Home Care FY 96 Budget and Projected Revenue (attached).

4. Medical/Dental Insurance -

Beginning July 1, 1994, the Health District offered Employee Plus One employer-paid coverage, through the Town of Westport. The FY 95 actual increases for insurance were negligible. Anticipated increase for FY 96 is 5%.

NO CHANGE

Operating Expense Changes:

1. Medical Consultant -

The Medical Consultant position has been underfunded and needs to be brought to a competitive level. the State requires a Medical Consultant in a health district if there is a non-physician Director of Health. The physician is available to staff for consultation on health and medical care issues and advises the Board of Directors on policy relating to personal health services.

For State licensure, medical consultation and supervision in the expanded daily nursing clinic, additional medical consultation services of an internist or family practitioner will be required.

FY 95 Budget                      \$10,000

FY 96 Budget                      \$15,000

Budgeted for additional \$5,000

2. Community Health -

- a. Health Promotion and Disease Prevention which includes the Well-Child Program. Pre-school audio visual screening, lead testing of homes with children and Community Health Education about radon, lead, Lyme Disease, cancer, etc.

FY 95 Budgeted at              \$4,800

FY 96 Budgeted at              \$5,300

Budgeted for additional \$500

- b. Communicable Disease Prevention, Surveillance and Control which includes immunizations, health education for International Travel, Sexually Transmitted Disease and Bloodborne Diseases, Lyme Disease, Foodborne outbreaks, Tuberculosis, surveillance of all reportable diseases, case investigation for selected diseases, Tuberculosis testing and

weekly HIV Counseling and Testing Clinic (reduced from 6 hours to 5 hours/week).

FY 95 Budget	\$21,960
FY 96 Budget	\$18,290
<u>Budgeted for reduction of (-) \$3,670</u>	

- c. Chronic Disease Preventions and Control which includes weekly hypertension screenings; adult health screening and monitoring clinics conducted monthly at the senior centers and senior housing; monthly mammography screening, and annual skin cancer screening.

FY 95 Budget	\$ 5,400
FY 96 Budget	\$ 4,600
<u>Reduction of (-) \$800</u>	

- d. Expanded Daily Clinic - Expansion of the hours of the Daily Clinic, staffed by a contract family nurse practitioner, was postponed to FY 96. A broader range of clinical services including physical assessments, expanded screening, and immunizations will be provided. A sliding scale will be instituted.

FY 95 Budgeted at 0.4 FTE	\$24,000
FY 96 Budgeted at 0.4 FTE	\$24,000
<u>NO CHANGE</u>	

- e. Periodic Screenings - These screenings will be scheduled periodically as events and will include a large number of cancer screenings, visual acuity and glaucoma, diabetes screenings, etc. The family nurse practitioner, under contract, will provide the services.

FY 95 Budgeted at 0.4 FTE	\$ 6,000
FY 96 Budgeted at 0.4 FTE	\$ 6,000
<u>NO CHANGE</u>	

- f. Public Information and Communication - In addition to the development of displays, brochures, media presentations, and a bi-monthly calendar, the Health District has hired a consultant to generate and provide an ongoing stream of useful and beneficial information to the public.

FY 95 Budgeted at	\$25,000
FY 96 Budgeted at	\$24,000
<u>Reduction of (-) \$1,000</u>	

## ***APPENDIX H***

***Average Salaries for Connecticut Health District Personnel***

***Small, Medium, and Large Connecticut Health Districts  
Average Salaries, Benefits, and Operating Expenses***

# AVERAGE SALARIES FOR CONNECTICUT HEALTH DISTRICT PERSONNEL

Town/District	Results		Salary	Survey	Sanitarian	Health Educ.	Nurse	Office Mgr.	Notes
	1994 - 1995	Fiscal		Year					
	Dir. of Health	Chief Sanit.	Senior Sanit.						
Farmington Valley H.D.	\$72,000	\$51,500	\$40,000		\$36,050			\$27,000	sec-22,500
Westport/Weston Health D.	\$69,465	\$37,888			\$33,275	\$33,088	\$55,000	\$28,862	Clerk-24,247
North Central H.D.	\$68,000	\$44,700			29,000-38,000			\$28,000	sec-27,500
Bristol/Burlington H.D.	\$67,500	\$47,580	44539		\$38,869	\$29,000	\$36,615	\$45,500	
Uncas Health Dist. *	\$64,400	\$40,000	31,400			\$30,000	29,000-33,000	\$26,000	
Naugatuck Valley H.D.	\$63,000	\$47,000	\$41,000		27,000-32,000	\$38,000		\$26,000	
Northeast Health Dist.	\$63,000	\$47,000	\$36,000		29,000-33,000			\$32,922	sec-20,700
Torrington Health Dist.	\$62,400	\$52,725			34,300-39,300	\$42,246	18/hr	\$34,000	
Quinnipiac Health Dist.	\$58,560	\$47,995	\$35,471		\$35,000	\$42,246	na	\$30,532	
Pomperaug Health Dis.	\$56,578	\$42,882	na		\$29,160	\$33,280	\$30,532	\$25,369	
Chesprocott Health Dist.	\$53,000	\$43,860			27,000-33,725	\$33,750	17.06/hr	\$25,725	
Ledge Light H.D. *	\$50,000				27,500 - 34,500	31,000 - 33,500	na		
<b>Average Salary</b>	<b>\$62,325</b>	<b>\$47,137</b>	32,700 - 41,000					23,400 - 29,250	

Note: Asterisk\* denotes fiscal 1993 - 1994 data

Source: Pomperaug Health District

## SMALL REGIONAL HEALTH DISTRICTS IN CONNECTICUT (POPULATIONS UNDER 40,000)

<b><u>SALARIES:</u></b>	<b><u>LLHD</u></b>		<b><u>WWHD</u></b>		<b><u>POMP</u></b>		<b><u>NTN</u></b>
TOTALS:	296,460		438,928		248,785		185,614
	AVERAGE: \$292,446.81						
	RANGE: \$185,500 TO 435,000						
<b><u>FRINGE (BENEFITS):</u></b>	<b><u>LLHD</u></b>		<b><u>WWHD</u></b>		<b><u>POMP</u></b>		<b><u>NTN</u></b>
TOTALS:	80,044		123,222		61,116		56,364
% OF SALARY TOT:	27%		28%		26%		30%
AVERAGE:			\$80,186				
AVE. % OF SALARY:			27.75%				
RANGE:			26% TO 30%				
<b><u>OPERATING EXPENSES:</u></b>	<b><u>LLHD</u></b>		<b><u>WWHD</u></b>		<b><u>POMP</u></b>		<b><u>NTN</u></b>
TOTALS:	80,520		127,725		59,951		28,916
AVERAGE:			\$74,278				
RANGE:			\$29,000 TO \$128,000				



### OPERATING EXPENSES FOR SMALL RHD IN CT

OE (AVE. % OF OE)	STAFF	LLHD	WWHD	POMP	NTN
TELEPHONE (7.1%)	1700(8.1)		9500(7.5)	5000(8.3)	1260(4.4)
RENT (12%)	T.HALL		6000(4.7)	11580(19)	
DUES/PUB. (1.17%)	350(.67)	525(.65)	2250(1.8)	400(.7)	300(1)
OFFICE SUPPLIES (6.14%)	400(1.9)	7400(9.2)	9500(7.4)	5000(8.3)	1125(3.9)
UTILITIES (6.85%)			11075(8.7)	3000(5.0)	
AUTO (24.65%)		13800(17)	7200(5.6)	15280(25)	14747(51)
OFFICE EQUIPMENT (6.13%)		5000(6.2)	5000(3.9)	5000(8.3)	
AUDIT/ACCT. (4.52%)	500(2.4)	3200(3.9)	5600(4.4)	2000(3.3)	2500(8.6)
LEGAL (2.65%)		1200(1.5)	5000(3.9)	1000(1.7)	1000(3.5)
TRAINING (4.06%)	1200(5.7)	2400(3.0)	3000(2.3)	1000(1.7)	2200(7.6)
PERCENTAGES = THE PERCENTAGE OF TOTAL OPERATING EXPENSES--FOR EACH EXPENSE ACCOUNTED FOR IN THE SMALL RHD BUDGETS.					

<u><b>SALARIES:</b></u>		<u><b>ESD</b></u>	<u><b>WHBD</b></u>	<u><b>BBD</b></u>	<u><b>NED</b></u>	<u><b>UHD</b></u>	
	TOTALS:	241,012	454,591	470,391	382,390	242,979	
	AVERAGE: \$ 358,272.77						
	RANGE: \$ 240,000 (40,000 TO 55,000 POP.) TO 470,000 (OVER 55,000 POP.)						
<u><b>FRINGE(BENEFITS):</b></u>		<u><b>ESD</b></u>	<u><b>WHBD</b></u>	<u><b>BBD</b></u>	<u><b>NED</b></u>	<u><b>UHD</b></u>	
	TOTALS:	61,000	170,816	178,749	107,800	94,056	
	% OF SALARY TOT:	25%	37.50%	38%	28%	24%	
	AVERAGE: \$122,484						
	AVE. % OF SALARY: 30.5%						
	RANGE: 24% TO 38%						
<u><b>OPERATING EXPENSES:</b></u>		<u><b>ESD</b></u>	<u><b>WHBD</b></u>	<u><b>BBD</b></u>	<u><b>NED</b></u>	<u><b>UHD</b></u>	
	TOTALS:	92,333	90,293	156,070	117,850	53,400	
	AVERAGE: \$101,989.20						
	RANGE: \$53,000 TO \$156,000						

## OPERATING EXPENSES FOR MEDIUM SIZED RHD IN CT

OE (AVE. % OF OE)	ESD	WHBD	BBD	NED	UHD
TELEPHONE (4.74%)	3900(4.2)	3207(3.6)	6500(4.2)	7500(6.7)	2670(5)
RENT (23.05%)	12000(13)		28070(18)	25000(21)	21360(40)
DUES/PUB. (.42%)	400(.43)			500(.4)	
OFFICE SUPPLIES (4.82%)	4200(4.5)	7221(8.0)	4200(2.7)	7000(5.9)	1602(3)
UTILITIES (2.2%)	2040(2.2)				
AUTO (6.025%)	6780(7.3)	7520(8.3)		7000(4.5)	2136(4)
AUDIT/ACCT. (7.56%)	2800(3)	14000(16)	4200(2.7)	4300(3.6)	6942(13)
LEGAL (3.3%)	1000(1.1)		5000(3.2)	7000(5.9)	1602(3)
PRINTING (1.67%)		211(.23)	4000(2.6)	1000(.84)	1602(3)
OFFICE CLEANING (3.3%)	2100(2.3)			2000(1.7)	3204(6)
PERCENTAGES = THE PERCENTAGE OF TOTAL OPERATING EXPENSES--FOR EACH EXPENSE ACCOUNTED FOR IN THE SMALL RHD BUDGETS.					

LARGE DISTRICTS (OVER 30,000)SALARIES

	<u>IAHD</u>	<u>OKHD</u>	<u>EVHD</u>	<u>NCD</u>	<u>NKHD</u>
<u>TOTALS:</u>	433,646	417,623	399,516	330,000	519,686
	AVERAGE SALARY:		\$ 424,095		
	RANGE:		\$ 330,000 TO \$ 520,000		

FRINGE (BENEFITS)

	<u>IAHD</u>	<u>OKHD</u>	<u>EVHD</u>	<u>NCD</u>	<u>NKHD</u>
<u>TOTALS:</u>	112,726	142,976	105,567	86,336	137,782
<u>% OF SALARY:</u>	25%	34%	26%	26%	27%
	AVERAGE FRINGE:		\$ 117,477.60		
	AVERAGE % OF SAL.:		27.60%		
	RANGE:		25% TO 34%		

OPERATING EXPENSES

	<u>IAHD</u>	<u>OKHD</u>	<u>EVHD</u>	<u>NCD</u>	<u>NKHD</u>
<u>TOTALS:</u>	161,756	119,322	90,879	119,144	150,427
	AVERAGE OPERATING EXPENSE:		\$128,305.60		
	RANGE:		\$91,000 TO \$160,000		

OPERATING EXPENSES

OE (AVE. % OF OE)	<u>IAHD</u>	<u>OKHD</u>	<u>EVHD</u>
TELEPHONE (5.4%)	10500(6.5)	4200(3.5)	4500(5)
RENT (15%)	13570(8.4)	36210(30)	11200(12.3)
DUES/PUB. (.78%)	1500(.9)	735(.6)	900(.99)
OFFICE SUPPLIES (5.94%)	6500(4)	3200(2.7)	3000(3.3)
AUTO (13.24%)	13114(8.1)	9500(8)	21090(23.2)
AUDIT/ACCT. (3.07%)		3744(3.1)	3000(3.3)
LEGAL (.88%)			1000(1.1)
POSTAGE (2.1%)	1700(1.1)	3100(2.6)	2200(2.4)

CONTINUED FOR THE TWO OTHER LARGE DISTRICTS INVESTIGATED

OE (AVE. % OF OE)	<u>NCD</u>	<u>NKHD</u>
TELEPHONE (5.4%)		10000(6.6)
RENT (15%)	9100(7.6)	25000(11.8)
DUES/PUB. (.78%)		1000(.66)
OFFICE SUPPLIES (5.94%)	16300(13.7)	9000(6)
AUTO (13.24%)	8315(7)	30000(19.7)
AUDIT/ACCT. (3.07%)		4200(2.8)
LEGAL (.88%)		1000(.66)
POSTAGE (2.1%)		3500(2.3)

## ***APPENDIX I***

### ***Estimating Revenue From Fees For A Health District***

## ESTIMATING REVENUE FROM FEES FOR A HEALTH DISTRICT

<i>Service</i>	<i>Farmington Valley HD</i>	<i>Northcentral HD</i>	<i>Torrington HD</i>	<i>Estimated Fee</i>	<i># in Region</i>	<i>Total Value</i>
Restaurant	\$75-300	\$100-200	\$50-100			
Caterer	\$75	\$100				
Itinerant Vendor	\$75	\$50-75	\$50			
Food Store	\$150	\$50-150				
Private School	\$150	\$100	\$100			
Nursing Home	\$150	\$100-200	\$50-100			
New Septic	\$50	\$75	\$150			
Septic Repair	\$50	\$50	\$50			
Wells	\$25	\$50	\$50			
Day Care	\$50	\$50	\$40			
Camps	\$150		\$40			
Hair			\$30-100			
Deep Hole/Perc		\$65-100	\$100			
TOTAL						

STATE GRANT-IN-AID REVENUE  
FOR A HEALTH DISTRICT

<i>Town</i>	<i>Estimated Total Population</i>	<i>×</i> <i>Rate</i> <i>1.78 or 1.52</i>	<i>=</i> <i>Public Health Grant</i>
<b>Total</b>			



## ***APPENDIX J***

### ***Worksheets For Step Eight: Drafting A District Proposal***

## WORKSHEETS FOR DRAFTING A DISTRICT PROPOSAL

### Fiscal Impact

Current municipal public health expenditures per capita	\$
Municipal per capita contribution to proposed district	\$
DIFFERENCE	\$

### Programmatic Impact

<i>Staff</i> Position	District guidelines	The town's health department now offers	The district will provide the town
Director of health	Full-time with MPH experience in public health administration and health planning.		
Medical advisor	Needed if director of health is not an M.D. May be on contract.		
Sanitarians*	Complete staff of full-time registered sanitarians, based on population of district.		
Health educator/nurse*	Optional.		
Other staff*	Secretarial/Clerical		
Back-up staff	Pooling of manpower and formal arrangements for back-up services in emergencies.		

\* note if any staff will transfer to new district.

### Programmatic Impact (continued)

<i>Services</i> Area	District guidelines	The town's health department now offers	The district will provide the town
Availability of services	Services available full-time, including 7 days a week, 24 hours for emergencies.		
Scope of services	<ul style="list-style-type: none"> <li>• health promotion and education</li> <li>• communicable and chronic disease control</li> <li>• maternal and child health</li> <li>• emergency preparedness, including hazardous and toxic waste</li> <li>• environmental health services.</li> </ul>		
Plans assuring availability of basic public health services	Comprehensive, written plans assuring basic public health services.		
Efficient utilization of existing public health service network	Responsible for coordination of existing services--focus on reducing waste, duplication or fragmentation.		
Regional health problems	A regional approach to health problems that cross town lines.		

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